the refugee family trying to go back to the country that they were expelled from who are dying from them. We have to do more.

I wish there would be a day when there would never be another war. There will not be. We can't stop that. But we can take steps to stop the day that landmines will ever be used again.

I yield the floor.

AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

The PRESIDING OFFICER. The Senate will now resume consideration of the agriculture appropriations bill, S. 1233, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1233) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2000, and for other purposes.

Pending:

Dorgan (for Daschle) amendment No. 702, to amend the Public Health Services Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

Lott amendment No. 703 (to amendment No. 702), to improve the access and choice of patients to quality, affordable health care.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, what is the business before the Senate at this time?

The PRESIDING OFFICER. The Senate is currently considering S. 1233, the agriculture appropriations bill and the pending amendment is amendment No. 703.

Mr. KENNEDY. Mr. President, now we are back to where we were yesterday just about 24 hours ago. At the request of the Democratic leader, the amendment on the Patients' Bill of Rights was submitted to the Senate as an amendment on the appropriations bill yesterday afternoon. The majority leader then offered an amendment to that amendment, which was effectively the legislation that was passed out of the Health and Education committee some 3 months ago and the tax provisions from the Senate Republican leadership proposal. That is an amendment to Senator DASCHLE's proposal.

We have this measure now before the Senate. Many of us over the last 2 years have tried to gain the opportunity to debate what we call the Patients' Bill of Rights. The underlying concept of the Patients' Bill of Rights is very simple and very straightforward. Our legislation has the strong and compelling support of over 200 organizations all across this country. Medical decisions that affect the members of our families ought to be made by doctors—by professional, trained medical personnel—and the patients. They ought to be the ones that make the decisions that are going to affect our lives and the lives of our families, our grandparents, and our children. Those decisions should not be made by an insurance agent, or by an HMO official.

This is a very basic and fundamental concept, and all of the basic measures—the proposals—that are advanced in our Patients' Bill of Rights, which was introduced by Senator DASCHLE, reflect this concept. The Republican proposal does not address this critically important concept. I call the Republican proposal the ''patients' bill of wrongs.'' They use the right words in their title, but that's it. Their bill doesn't guarantee that these decisions are going to be made by the doctors and nurses and by the trained medical professionals.

The Members of this body do not have to take what I say on this interpretation of the Republican proposal. The fact remains that we have been waiting and waiting and waiting for well over a year, or for close to 2 years, to hear from our Republican friends about the medical associations or the medical professionals that support their proposal. Let's be clear, we don't advance this proposal because we are Democrats. We advance it because it will protect consumers and families in this country.

It isn't that I say it, or that Senator DASCHLE says it, or that any of our colleagues say it. It is because the doctors in this country say it. The American Medical Association says it. The American Nurses Associations says it. The consumer organizations that have been dedicated to protecting patients have said it.

If you look over the list of those various groups that are supporting our particular proposal, you will find that virtually every organization that represents women's health care support our legislation, and for very good reasons, which we will outline today. Virtually every leading group that has dedicated itself to protecting the well-being of children in our society and the health care of children are supporting our proposal. Why? For very good reasons, which have been outlined before by Senator DASCHLE, Senator REED and those of us who support helping children. You will find that virtually every organization in this country that is concerned about the needs of the disabled in our society is supporting our program. Virtually every group that is concerned about cancer and cancer research is supporting our particular proposal. And virtually none are supporting the opposition's proposal.

This is something that the American consumers ought to understand. This is something the American consumers ought to realize.

I see our leader on the floor at this time. I think all of us are looking forward to listening to his presentation.

I yield the floor at this time and will come back and address the Senate.

Mr. DASCHLE. Mr. President, if the Senator will yield, he was talking earlier about the amazing array of groups in support of our bill. I think I heard the Senator say it really represents virtually the entire universe of health care provider organizations that we know in this country. Certainly they are not all necessarily Democratic groups or progressive groups.

Would the Senator comment on the diversity of the groups supporting our proposal? I think this is a point that is sometimes lost—the breadth of organizations that say this is a top priority as a legislative issue.

Mr. KENNEDY. As the Senator knows full well, we can take one example. There are many, and we will come back to those later in the afternoon. But the Senator has been a strong supporter in terms of increasing the NIH research budget and has followed the various recommendations so that hopefully we are going to double the NIH research budget. Our Republican colleagues have supported this proposal. Senator MACK and Senator SPECTER have been leaders. Senator HARKIN has been one of the important leaders. Many other Members have supported that proposal. Why? Because it is universally accepted that we are in the early morning sunrise period of major scientific breakthroughs on many of the kinds of diseases that affect millions of our fellow citizens.

This year, more than 563,000 will die from cancer, and 1.2 million will be diagnosed. We have these enormous potential breakthroughs that can mean the difference between life and death. These breakthrough treatments allow individuals some degree of hope of being freed from Alzheimer's or Parkinson's disease or cancer. Every medical researcher understands that. That is why they support the access to clinical trials piece in our proposal. When they have the breakthrough in the laboratory, they want to get it to the bedside. The way that is done is through clinical trials.

Under the Daschle proposal, we would continue the traditional support for clinical trials so that we can move these breakthroughs that are coming in the laboratory to the patients, to the mothers, and to the daughters, and to others.

Mr. DASCHLE. Will the Senator explain the term ''clinical trials?'' The Senator has made such an important point about this issue. There are so many differences between the Republican and Democratic bills. One of the myriad of differences has to do with the so-called ''clinical trial'' provision. The Senator has spoken on the floor so patiently and eloquently about the

concept of clinical trials and access to them. When we talk about clinical trials, are we talking about innovative techniques to respond to health problems that take full advantage of research and the opportunities of medicine that this country provides? Are we talking about giving people access to that medicine and cutting-edge technology just as soon as it is available?

Isn't that really what we are talking about?

Mr. KENNEDY. The Senator is absolutely correct.

If I could add to what the Senator has said, we have made great progress in dealing with cancer, especially children's cancers, over the last 10 years. The principal reason for this progress is the large number of clinical trials. We should take the time to spell out what has actually happened in the clinical trials and why that is an important provision of the leader's Patients' Bill of Rights.

Mr. DASCHLE. We should talk about clinical trials and how critical they are.

I ask the Senator if he could inform Members what impact it would have on an individual were he or she able to have access to clinical trials today under this bill?

Mr. KENNEDY. Senator, I will speak from a personal point of view. My son was 12 years old when he was diagnosed with osteosarcoma, bone cancer. Chances of survival were 15 percent; the mortality rate was 85 percent. We were able to enroll my son in a National Institutes of Health clinical trial, which only 22 children had gone through successfully. He was in that program for 2 years. By the time he finished, they had more than 400 children taking part in that program who survived osteosarcoma, with a breakthrough new treatment for osteosarcoma. Seven thousand children are affected every single year. At that time, the loss of a leg was a matter of course; it is not at the present time.

There is no question that not only my son but many of the other children would not likely have survived had they not participated in the clinical trial. That treatment for osteosarcoma is now the standard treatment and is saving countless children's lives.

There are many other examples. Our greatest progress in cancer research and in treating cancer has been a direct result of clinical trials.

Mr. DASCHLE. If the Senator would yield for a clarification, is the Senator saying that in many cases today insurance companies and managed care organizations are refusing to allow a patient access to the very kind of treatment that you say your son received? Is that what is going on?

Mr. KENNEDY. Not only am I saying that, but most important is that the directors of the Lombardi Cancer Research Center, located here in Washington, DC, one of the major centers in the country in cancer research programs and clinical trials, is saying that as well. The director says they employ eight professionals who work 18 hours a day combating health maintenance organizations to help enroll women in breast cancer clinical trials. Doctors have recommended patients for clinical trials, with treatment that can probably save their lives, but due to resistance and denials by the health maintenance organizations, those women are effectively denied treatment that may save their lives. That is happening today.

As the Senator knows, all we are trying to do with this particular proposal is follow sound medical guidelines, the medical guidelines that your doctor—who may be an oncologist acting on behalf of a victim of breast cancer—believes, given the clinical trials taking place, providing you a real chance of surviving if we enlist you in the clinical trial; this is in your medical best interest.

Your bill says your physician's medical determination is going to be the controlling judgment. It isn't going to be an accountant in the HMO who says: We don't believe that treatment is justified and we are not prepared to pay for it; I am making the medical judgment—even though I am trained as an accountant.

Mr. DORGAN. Will the Senator yield?

Mr. KENNEDY. I am happy to yield to the Senator.

Mr. DORGAN. The Senator is talking now about specifics, and Senator DASCHLE was asking about clinical trials.

Let me ask another specific. Regarding emergency room treatment. Senator KENNEDY makes the point there is the Patients' Bill of Rights on this side and the Patients' Bill of Rights on that side. But they are not the same. There is a big difference.

Let me give an example regarding emergency room care. I told the story of a case of a woman named Jacqueline the other day. Jacqueline is a real person. She was hiking in the Shenandoah. While hiking in the Shenandoah, she slipped and fell down a 40-foot cliff. She fractured three bones in her body, including her pelvis. She was unconscious. She was medivac'ed by helicopter, taken to a hospital emergency room, and treated. She survived.

The HMO said: We don't intend to pay for your emergency room treatment because you didn't have prior approval to go to the emergency room.

This is a woman who was unconscious.

The Patients' Bill of Rights that the AMA and so many other groups have endorsed—they have written in support—is different from the bill the majority party offers in the emergency room treatment in the sense that we require not only the ''prudent'' layperson standard in emergency care and emergency room, but we require also the poststability care that is necessary after you have been to an emergency room, and their bill does not do it.

Mr. KENNEDY. The Senator is absolutely correct. We have had constant examples of abuses that have taken place. Senators have printed in the RECORD these human tragedies.

The Senator understands fully that this is not only something from last year or something from last month. The situation the Senator has outlined is happening today. It has happened this morning; it has happened this afternoon; it will happen tomorrow. It will continue to happen unless and until we pass this legislation.

Mr. DORGAN. I just described a case of a woman being hauled into the hospital unconscious and being told: We can't pay your bill because you didn't get prior approval for emergency room treatment.

That is absurd. That is the kind of horror story that requires all Americans to believe we must pass a Patients' Bill of Rights that has teeth and works to solve real problems.

Isn't it the case, with respect to emergency room care, that we in this Congress have already given all senior citizens in the Medicare program exactly what is proposed in our bill with respect to emergency room treatment and poststability care? Isn't it the case that every Member of the Senate has already voted for that in Medicare, saying yes, that is the right thing to do; but when it comes to the Patients' Bill of Rights they say: We want to have a Patients' Bill of Rights, but on our emergency room care, we don't intend to offer that protection on not only emergency room care but also poststability care in a hospital after you get out of the emergency room; we don't intend to offer that, even though we have already done that and voted for it for Medicare patients.

I don't understand the contradiction; does the Senator from Massachusetts?

Mr. KENNEDY. The Senator has correctly stated the current situation. It isn't only Medicare. It is also in Medicaid, as well as the Federal Employees Health Benefits Program. Every Senator has these protections.

The interesting question I ask the Senator, if these protections were such burdens on the delivery system, doesn't the Senator think he would have heard? These protections are available today, for those who are covered with Medicaid or Medicare. The other side in opposition to the Daschle proposal is always saying these protections are burdening the system, and we can't protect all Americans because it will burden the system?

The Senator has made the correct point. We do it today in Medicaid. We

do it in Medicare. We do it for Federal employees. Most of the good HMOs do it. It is the bad apples that are threatening the well-being and the health of many of the citizens in our States whose procedures we need to address.

Mr. DORGAN. I will respond, if the Senator will yield to me further, with the story I told on the floor of the Senate, about the woman who was also injured, whose brain was swelling and who was in an ambulance being taken to a hospital and who said to the ambulance driver, I do not want to go to X hospital. She named the hospital. I want to go to Y hospital farther down the road. This woman lying in the back of an ambulance with a brain injury said: I want to go to the hospital farther away. Why did she say that? Because she read that the hospital that was closest had made decisions about patients' care that were more a function of corporate profit and loss than they were about health care, and she did not want, with a brain injury, to be wheeled into the emergency room with the notion somebody was going to look at her and make a dollar-and-cents decision about her health care.

Mr. DASCHLE. If the Senator will yield on that point, I would like to comment. I think what he has noted is exactly another reason why it is so important for us to have a debate about access to emergency rooms and other necessary care.

I would note that just the opposite of what the Senator describes oftentimes occurs. A managed care company, or an HMO, actually will make you drive past the nearest hospital to go to a hospital farther away, where they have a contract.

Sometimes a patient will choose not to use the nearest hospital, for a lot of reasons—better care, preferred specialists, different services. A patient may want to go farther away. But, in many cases, maybe a preponderance of cases, they actually have to drive past hospitals to go to the hospital the HMO has chosen, rather than the one they would choose for themselves.

Again, I think the Senator makes a very good point.

Mr. KENNEDY. May I just make this point? Access to emergency care, which is carefully protected in the leader's legislation, does the leader know that the provisions in his legislation were almost unanimously supported in the President's Commission on Quality Care? The one exception is the President's Commission did not make the recommendation that it be put in law, although they said every quality health maintenance organization ought to have it.

Second, the American Association of Health Plans has recommended it. They do not mandate it, but they recommend it, saying it is essential in providing care.

The National Association of Insurance Commissioners—not a Democratic group, the majority of Insurance Commissioners are probably Republicans—has recommended it for the States. They say, in the States, as a matter of good quality health care, they ought to have the provisions which are in our Patients' Bill of Rights. As the Senators have pointed out, it has been included in Medicare.

So this proposal, which was offered and defeated in the Health, Education, Labor and Pensions Committee, should be a matter where we have an opportunity to present it and let the Senate make a judgment. As I mentioned, it has been recommended by the nonpartisan commission. It has been recommended by the independent insurance commissioners. It is in Medicare. We would like to hear on the floor of the Senate those individuals who are opposed, those individuals who say no to this particular protection. That is the kind of protection that is included in the Daschle proposal, which is of such importance.

Mr. President, I see others want to speak on this proposal.

In looking down this list of protections, you can ask yourselves: Where do these protections really come from? As I mentioned, the protections we have put into the Daschle proposal are effectively the ones supported by the President's commission, the American Association for Health Plans, and the Insurance Commissioners. It is in Medicare. It is working, and it is working effectively. We do not have examples that protecting those under Medicare is a burden, and I do not think those who are opposed to that particular proposal can make an effective case in opposition to this provision.

I will take the time later to mention two or three more protections. Virtually every one of these protections is either part of a recommendation from the President's commission, part of the recommendations of the American Association of Health Plans, recommended by the state Insurance Commissioners, or is being implemented and protecting persons covered under Medicare.

These are commonsense proposals. They are not protections we have suddenly grabbed from some way-out organization or group. They are fundamentally rooted in sound health care practices. That is the case we want to bring to the floor of the Senate.

I see my colleague and friend on the floor now, wishing to speak. I will be back to address the Senate shortly.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I thank my colleague from Massachusetts. First, on this issue of the Patients' Bill of Rights, I ran for the Senate in part so I could address this issue, which is of critical importance to the people of North Carolina and the people of America, in a completely nonpartisan way. I am not interested in engaging in partisan politics between Democrats and Republicans. What I am interested in is a real discussion about an issue that is absolutely critically important to the people of this country and the people of North Carolina. Let me talk briefly about one aspect of the Patients' Bill of Rights that I think is so important.

Imagine there is a 29-year-old woman who lives in the Research Triangle of North Carolina which is between Raleigh-Durham and Chapel Hill, between Duke University Medical School and the University of North Carolina Medical School. Let's assume she is the mother of two children, having recently had a young child, born 6 months ago. She goes in for a postpartum checkup after the birth of her child, and the doctor looks at a mole on her back that seems suspicious. After some further testing, it is confirmed that her and her family's worst nightmare is true; she has a melanoma.

After they do further investigation, they determine there are clinical trials going on at Duke University Medical Center, just down the road from where she and her family live, which could provide lifesaving treatment for her condition. So she goes to her HMO and says: I want to be part of this; I want to make sure I have access to the best health care available. Literally, her life is as stake. She finds out from her HMO, unfortunately, that Duke is not part of the network of her HMO. So, as a result, treatment for her melanoma, which is so critically needed, is not available.

Here we have a situation where a simple thing is true. An HMO system, a health insurance system, a health insurance company, should not be able to stand between this woman and the lifesaving medical treatment she so badly needs and her family so badly needs for her. A real Patients' Bill of Rights would ensure that someone in her condition would have access to the best specialty care available, whether or not that care is within or without her HMO network. It would ensure, in my example, that she could, in fact, go 15 miles down the road to Duke University Medical Center and get the treatment that may well save her life—the life of a mother and a wife.

This is the kind of thing we need to be doing something about in the Patients' Bill of Rights. She should not be confronted with an obstacle course in order to get the treatment she needs and deserves. She needs to have ready, direct access to the care she obviously needs under these circumstances. That was an illustration.

I want to talk, secondly, about a real-life example. We received a phone call in my office from a young man who lives in Cary, NC, which is just

outside of Raleigh. His name is Steve Grissom. Fifteen years ago, Steve Grissom was diagnosed with leukemia. The truth is, for most people, that would be an extraordinary life-altering and devastating thing to have occur. Unfortunately, that is not the end of the problem for Steve Grissom.

In 1985, because of his leukemia, he was required to have a blood transfusion. Most folks who are listening to this story probably know where it is headed. As a result of this blood transfusion, which he had to get because of his leukemia, he now has AIDS. He got AIDS as a result of the blood transfusion.

With the onset of AIDS, he had multiple medical problems. Included among those medical problems was the development of something called pulmonary hypertension which made it very difficult for him to breathe. The doctors who treated him prescribed oxygen 24 hours a day, 7 days a week to help him maintain his oxygen level. This prescription was made by a pulmonary specialist at Duke University, something that was clearly needed to save his life.

He was doing fine. Then his employer changed health care companies, unbeknownst to him. When the new HMO took over, they cut off payment for the oxygen that Steve had been dependent on for a long time now—24 hours a day, 7 days a week.

Let me tell you how that decision was made. It was not made by some medical doctor who examined Steve and decided he did not need this treatment. It was not made by a specialist who had a different opinion than the pulmonary specialist at Duke University. Instead it was made by a clerical/bureaucratic person at the HMO sitting behind a desk looking at papers. The conclusion that person came to was that his oxygen saturation levels were not sufficiently low under their criteria to justify him receiving oxygen 24 hours a day, 7 days a week, even though the most highly trained medical specialist in the area at Duke University Hospital had prescribed this oxygen for him. He said it was lifesaving, absolutely critical.

The result of all this was basically an insurance company bureaucrat sitting behind a desk overrode a doctor who has spent his life in this area, who had become one of the best known pulmonary specialists in the country at Duke University, who had prescribed this oxygen therapy for Steve. Here is a man who has been confronted with extraordinary setbacks in his life, the kinds of things that would put most of us under the ground.

Here is the extraordinary thing about Steve Grissom. He has continued to fight. Even though his health insurance company now says they will not pay for the care he needs, he has managed to pay out of his own pocket for as much of this care as he can get.

He has called my office and said: I want to come to Washington. I want to testify. I want to talk to Members of the Senate, Members of the Congress. I want to tell them about the problem I am having getting any continuity of care which I so desperately need.

The truth of the matter is, what Steve Grissom is doing is he is fighting in every way he knows how to cease being a statistic, to stop being a name and a number on a piece of paper on somebody's desk sitting in an insurance company office.

He is an extraordinary example of heroism. He is the kind of person whom I think most of us would hold up to our children and members of our family as what we hope they will be when confronted with extraordinary, difficult setbacks.

He fought back. He got the blood transfusion he needed in 1985. When he was then confronted with something that would absolutely overcome most people, which is AIDS as a result of the blood transfusion, he continued to do everything in his power to get the treatment he needed and go forward with his life.

When he was on oxygen 24 hours a day, 7 days a week just to stay alive and his employer changed HMOs and they cut off payment for the treatment that kept him alive, he continued to fight. Here is the most extraordinary thing about it. Not only has he continued to fight, not only has he expressed a willingness to come and talk to Members of the Senate, to testify before this Congress about what he has been confronted with, there is absolutely no bitterness in this man. He has been kind and gracious. He has said: I want to do everything I can to ensure that what has happened to me does not happen to other Americans, does not happen to other North Carolinians. I want to explain to Members of Congress why it is so critically important that we pass a meaningful Patients' Bill of Rights, one that will protect people who are confronted with the kind of situation with which I am confronted.

The truth of the matter is, it is extraordinary that he is still alive. He continues to be a huge part of his family's life. He is, by any measure, a hero. But to the insurance company, Steve Grissom is a liability. He is somebody who costs $515 a month to pay for the oxygen that is needed to keep him alive.

The reality is that they made the decision about Steve Grissom for the same reason that HMOs and health insurance companies make these decisions all across the country, affecting children and adults and families all over this country every day. They did it based on the bottom line—profits. They had established an arbitrary criteria for what was necessary for somebody in Steve's situation to get oxygen therapy and treatment that he needed. Regardless of his individual situation, regardless of the fact that the doctors who were responsible for treating him, who are highly trained, highly specialized experts at Duke University Medical Center, had said he needs this treatment, they rejected it. They made the decision that no longer would he receive this oxygen, and they would not pay for it anymore.

I cannot help but believe the majority of Americans think that what has been done to Steve Grissom is wrong; that the courage he has shown in the face of extraordinary adversity is something that should be admired and looked up to. He is absolutely entitled to the benefit of the doubt, to the extent there is any doubt, that a specialist at Duke University has determined that he is entitled to this treatment that he so desperately needs.

Mr. KENNEDY. Will the Senator yield for a question?

Mr. EDWARDS. Yes.

Mr. KENNEDY. Given that this patient is denied the treatment that can make all the difference in restoring his health or well-being, and given that we have heard examples where, as a result of denying that treatment, a decision made by the health maintenance organization despite the recommendations of the medical professional—can the Senator tell me the remedies available? What remedies are available to a family whose loved one dies or whose loved one sustains a permanent injury because a judgment was made by the insurance company or the HMO, in conflict with the recommendation by the treating doctor. What remedy is available to that family that loses its breadwinner or has to care for an individual who is permanently injured for the rest of their life? What remedy is available for the family who loses a loved one due to the negligence or the clear malfeasance of the insurance company or the HMO?

Mr. EDWARDS. The Senator's question highlights an enormous problem in existing law and a problem that we are trying to desperately cure in this Patients' Bill of Rights.

Under the circumstance I have just described, if something happens to Steve Grissom, i.e., he suffers more serious injury or dies as a result of an arbitrary decision made by an insurance company bureaucrat, if that occurs, first of all, under the existing law, that HMO and that bureaucrat cannot in any way be held responsible. They are totally immune to responsibility, unlike every other American—you, I, any other American—who could be held accountable in court for that decision. They are totally immune from responsibility. They are protected.

As a result, they only have one incentive for what they do, and that incentive is the green dollar bill, the profit, the bottom line. It is the only thing that matters to them. That is the

basis on which these decisions are made.

Not only that, not only can they not be held accountable in court, I say to the Senator, there is not even an independent review board that can look at this decision that has been made and determine whether it is unfair, whether it is unjust, and whether it is medically unsound.

So basically, Steve Grissom and his family, in this life-threatening situation, are confronted with a circumstance where they have no remedy at all. They can do absolutely nothing.

Does that answer the Senator's question?

Mr. KENNEDY. Further, is the Senator suggesting that this is the only area in civil law that a remedy is really being denied on the basis of real negligence, malfeasance? Are these the only companies in America that have this sort of privileged position of being free from what I think most Americans would understand as accountability? Is that what the Senator is suggesting?

Mr. EDWARDS. That is exactly what I am suggesting, I say to the Senator.

I add, anecdotally, one of the things that the Senator knows, I have come from 20 years of having represented folks in court cases. One of the questions we always ask jurors in the process of jury selection is: Do you believe everyone should be treated exactly the same in this courtroom? Universally, the answer is yes. Because the American people are fairminded. They believe everyone should be treated equally, everyone should be treated the same. They believe in both personal and corporate responsibility, that everybody ought to be held accountable for what they do or do not do—the very same way we teach our children they should be held accountable for what they do or do not do.

Instead, under existing law in this country, we have decided HMOs and health insurance companies are privileged characters. They get treated in a way that no other American business is treated, that no other American citizen—the people who are listening to this debate—is treated. They are held responsible for what they do.

But for some reason, under the law, unless and until we are able to change it, HMOs and health insurance companies are treated in a very privileged way. They cannot be held responsible for what they do. Unfortunately, that has enormous consequences for people, for families, and for children. The consequence is they have no reason to do anything other than the profit motivation, and the bottom line, which is the dollar. That is one of the problems we are working desperately to cure in our Patients' Bill of Rights.

Mr. KENNEDY. Finally—because I see others on the floor; and this issue is going to be addressed in the Daschle proposal—I am wondering whether the Senator would agree with Justice William Young, a Federal judge on the Federal bench in Massachusetts, who was appointed by President Ronald Reagan, who said, after a very tragic case—and I will not review all of the facts here, but it was quite clear that there was responsibility by the insurance companies; and it will be self-evident in his quote; and there was a real injustice done—this is what Judge William Young, appointed by President Reagan, who prior to the time he served on the bench was a Republican, said:

> Disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent. This Court has no choice but to pluck the case out of State court . . . and then, at the behest of Travelers [Insurance Company]—

That is effectively the culprit—

> slam the courthouse door in [the wife's] face and leave her without any remedy. ERISA has evolved into a shield of immunity that protects health insurers . . . from potential liability for the consequences of their wrongful denial of health benefits.

That is the statement from the bench of a distinguished Federal judge who came down and eventually effectively testified about the injustice of this provision. As I understand it, the Daschle proposal addresses that inequity and unfairness, which the Senator has outlined.

Mr. EDWARDS. May I respond to that briefly, I say to Senator KENNEDY?

I would ask for a comment from you on this issue. In terms of talking to your constituents in Massachusetts, can you tell me what response you have gotten, including from health care providers, on the issue of whether it is important to them, No. 1, that there be an independent review board so when folks' claims are denied, they have some ready process to use to get relief, and, secondly, whether they believe it is fair for HMOs and health insurance companies to be treated completely differently than every other segment of American society?

Mr. KENNEDY. As the Senator knows, they have independent review. We have it under the Medicare proposal. It works. It works very effectively. It works pretty well. It is somewhat different in scope than was included in the Daschle proposal. I favor this one here, but there is an independent review. But not only in that measure, we have some 23 million Americans who are working for State and local governments that have the kind of protection that is favored in the Daschle proposal, and it is working very effectively.

One of the very important programs that has the kind of protections the Senator has favored and that I favor is what they call the Calpurse Program in the State of California, which has well over a million individuals who are part of that program with the kind of protections that are supported by the Senator.

What they have found out—we will have a chance to get into this, hopefully, at the time we get a debate on it—is that the cost of that whole program has not increased as much as the increase in health insurance nationwide, or even in the programs in California that do not have that protection.

Do you want to know why, Senator, I believe that is so? For the same reason we had the expert witnesses who appeared before Senator SPECTER's Appropriations Committee; and that is, because the HMOs take more time and attention to make sure the patients are going to get better kinds of health care and health care coverage. That basically means they are able to get a better handle on the cost.

So it makes a major difference in terms of the quality of health care, and it makes a major difference in terms of the protections of individuals.

I thank the Senator for his response.

Mr. SCHUMER. Would the Senator from North Carolina yield for a question?

Mr. EDWARDS. Yes.

Mr. SCHUMER. I thank the Senator.

I have been very impressed with what he has said. As the Senator knows, I have been advocating the Patients' Bill of Rights for quite a while. Just this week I had traveled to different parts of my State—to Long Island, to New York City, to Syracuse, to Rochester. Everywhere I went, I found an amazing thing: The providers, the doctors, including the medical society, the AMA, the nurses, the hospitals are allied with the patients. Usually they are at loggerheads. But they were allied together in asking for a real Patients' Bill of Rights, not a Patients' Bill of Rights in name only.

We do not want to go through putting something on the floor that says: Patients' Bill of Rights, and does not protect patients. We are worried about that.

The reason I think we want an open debate and not just: Well, here is your version; we will vote for it. Here is our version; we will vote it down. We are finished with the Patients' Bill of Rights—we do not want that because we do not want to be able to just go home and say we passed something and then 3 months from now the very same doctors, and others, will say: It doesn't do any good. You didn't do anything.

We went through this on guns. We were going to pass something in this body that did absolutely nothing. Then the very same people who say the gun laws do not work, or who tried to cripple and emasculate the provisions we passed, said the laws do not work.

So the question I ask is—here are some examples of inequities that I have come across. I just would like to

ask the Senator from North Carolina if he thinks the Patients' Bill of Rights would help in these instances; and they are just amazing.

One, an HMO denies high-dose chemotherapy for a man with lung and brain cancer, stating it is experimental. What was the HMO's solution? The claim agent told his family to get in touch with organizations that have fundraisers for patients denied HMO coverage. Can you imagine the gall of that? A man is dying of cancer. They find a solution that might work. There is finally some hope in the family. Not only does the HMO say, no, we won't pay for it, but at the same time they say go have some fundraisers while the person has cancer. How about this one——

Mr. DURBIN. I ask, if I might, will the Senator from North Carolina yield to me?

The PRESIDING OFFICER (Mr. GORTON). The Senator from North Carolina has the floor.

Mr. DURBIN. Will the Senator yield for the purpose of a unanimous consent request?

Mr. EDWARDS. Yes.

UNANIMOUS CONSENT REQUEST

Mr. DURBIN. Mr. President, I ask unanimous consent that the remaining 65 minutes of debate before the vote at 5:45 on the motion to table be divided as follows: 40 minutes under the control of Senator NICKLES on the Republican side and 25 minutes under the control of Senator KENNEDY on the Democratic side.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. KENNEDY. I yield 5 more minutes to the Senator from North Carolina.

Mr. EDWARDS. I thank the Senator. I will conclude my remarks. The point I make is so important, which is that this is not a partisan debate. This is not a debate and should not be a debate between Democrats and Republicans. I didn't come to the Senate to fight with my Republican colleagues. I came to the Senate to represent the people of North Carolina—Republicans, Democrats, Independents, whatever their politics. We desperately need to talk about the specific provisions of a real, substantive, meaningful Patients' Bill of Rights. That is what needs to happen. That is the reason we are on the floor today talking about this amendment. It is the reason this amendment has been attached to the agriculture appropriations bill.

We need desperately to talk about these issues because they are so critically important to the people of my State—all of the people of my State—and they are important to all Americans. We have to make sure that folks have direct access to specialty care. It does absolutely no good for us to have the most advanced medical care and treatment and research in the world in this country if folks can't get to it. Folks have to be able to have access to the high-quality medical care that is constantly advancing on a daily basis in medical centers throughout this country, including medical centers in my home State, including Duke University Medical Center, University of North Carolina, Bowman Grey, and East Carolina University.

We have great medical centers in North Carolina. But those folks and the care they can provide do no good whatsoever if they can't provide the treatment to the patients. That is where health insurance companies, HMOs, stand as a roadblock between the doctors and the health care providers who are spending their lives developing these lifesaving treatments and the patients who so desperately need them.

Steve Grissom, the gentlemen I described with leukemia and AIDS, is a perfect example. There are heroes all over this country, all over North Carolina, who are standing up and fighting battles against health problems that are critical to them and their families. We have to give them direct access to the treatment and care that can save their lives and change the lives of their families.

It is very simple. The bottom line is this: Patients, not profits, should be the bottom line in health care. That is what this Patients' Bill of Rights is about. We simply want an opportunity to talk about it to our colleagues, whom we respect, on the floor of the Senate, to talk about it to the American people. And I am telling you, the American people in their gut know that this is something that needs to be passed, needs to be done, and that health insurance companies and HMOs absolutely should not stand between children and families and the health care that, in many cases, can save their lives.

With that, I yield the floor.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I appreciate the accommodation and cooperation by my friend and colleague, Senator DURBIN from Illinois. There are several on this side who wish to speak on this issue as well. We have been wanting to speak for about the last hour.

I yield to the Senator from Vermont for 10 minutes.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. JEFFORDS. Mr. President, this is an important time for America to listen to this debate because the lives and health of individuals throughout this Nation are at stake. It is interesting to note, looking back to last year when the Democratic proposal came forward, at first they wanted it to be voted on immediately. Then we worked together on this side of the aisle and worked up a bill that we find is superior to theirs in many respects, which I will talk about later, and all of a sudden they didn't want to bring it up without 100 amendments. We could not get a time agreement to get to the bill. Even though some of the things sound quite dramatic and wonderful, when we analyze them, we find that in many respects we believe the majority's bill is superior.

First of all, the Patients' Bill of Rights Act addresses those areas of health care quality on which there is a broad consensus. It is solid legislation that will result in a greatly improved health care system for all Americans.

The Committee on Health, Education, Labor, and Pensions has been long dedicated to action in order to improve the quality of health care. Our commitment to developing appropriate managed care standards has been demonstrated by the 17 additional hearings related to health care quality. And Senator FRIST's Public Health and Safety Subcommittee held three hearings on the work of the Agency for Health Care Policy and Research (AHCPR).

Each of these hearings helped us in developing the separate pieces of legislation that are reflected in our Patients' Bill of Rights Act.

People need to know what their plan will cover and how they will get their health care. The Patients' Bill of Rights requires full disclosure by an employer about the health plans it offers to employees.

Patients also need to know how adverse decisions by a plan can be appealed, both internally and externally, to an independent medical reviewer. That is a critical difference. We emphasize good health care. Under our bill the reviewer's decision will be binding on the health plan. However, the patient will maintain his or her current rights to go to court. Timely utilization decisions and a defined process for appealing such decisions are the keys to restoring trust in the health care system.

Our legislation also provides Americans covered by health insurance with new rights to prevent discrimination based on predictive genetic information.

It ensures that medical decisions are made by physicians in consultation with their patients and are based on the best scientific evidence. And it provides a stronger emphasis on quality improvement in our health care system with a refocused role for AHCPR.

The other bill uses the generally accepted practice in the area which can deviate very strongly from best medicine. We give you best medicine.

Some believe that the answer to improving our nation's health care quality is to allow greater access to the

tort system. However, you simply cannot sue your way to better health. We believe that patients must get the care they need when they need it, not just after they go to court in a lawsuit to repair the damage.

In the ''Patients' Bill of Rights,'' we make sure each patient is afforded every opportunity to have the right treatment decision made by health care professionals. In the event that does occur, patients have the recourse of pursuing an outside appeal. Prevention, not litigation, is the best medicine.

Our bill creates new, enforceable Federal health care standards to cover those 48 million of the 124 million Americans covered by employer-sponsored plans. These are the very same people that the States, through their regulation of private health insurance companies, cannot protect.

What are these standards? They include: a prudent layperson standard for emergency care; a mandatory point of service option; direct access to OB/GYNs and pediatricians; continuity of care; a prohibition on gag rules; access to Medication; access to Specialists; and self-pay for behavioral health.

It would be inappropriate to set Federal health insurance standards that duplicate the responsibility of the 50 State insurance departments. As the National Association of Insurance Commissioners, put it: ''(w)e do not want States to be preempted by Congressional or administrative ac tions. . . . Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.''

Senator KENNEDY's approach would set health insurance standards that duplicate the responsibility of the 50 State insurance departments. Worse yet, it would mandate that the Health Care Financing Administration (HCFA) enforce them if a State decides not to adopt them.

Those of us who have been involved with this know what happened during the recent past when the HIPAA bill was passed on to HCFA. It was a mess. Almost nothing was getting done.

HCFA cannot even keep up with its current responsibilities. This past recess Senator LEAHY and I held a meeting in Vermont to let New England home health providers meet with HCFA. It was a packed and angry house, with providers traveling from New Hampshire, Massachusetts, and Connecticut.

It is in no one's best interest to build a dual system of overlapping State and Federal health insurance regulation.

Increasing health insurance premiums causes significant losses in coverage.

This is the main difference. You can promise a lot of things when you try to do them. But if the result of what you do is that up to 1 million people lose coverage because of the increased cost, that is not the way we ought to go.

The Congressional Budget Office (CBO) pegged the cost of the Democratic bill at six times higher than S. 326. Based on our best estimates, passage of the Democratic bill would result in a loss of coverage for over 1.5 million working Americans and their families. To put this in perspective, this would mean that would have their family's coverage canceled under the Democratic bill.

Mr. KENNEDY. Mr. President, will the Senator yield on that point?

Mr. JEFFORDS. On the Senator's time?

Mr. KENNEDY. On my time.

Mr. JEFFORDS. Yes.

Mr. KENNEDY. The Senator has referred to the loss in terms of coverage by the General Accounting Office. Will the Senator share that letter which allegedly reached that conclusion? Will the Senator put that in the RECORD at this time so we have a full statement of the General Accounting Office rather than just using the figure that the Senator used? Will the Senator make that whole letter a part of the RECORD?

Mr. JEFFORDS. I would be happy to make that a part of the RECORD, yes.

I ask unanimous consent that the letter be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See Exhibit 1.)

Mr. JEFFORDS. Let me repeat that. Adoption of the Democratic approach would cancel the insurance policies of almost a million and half Americans. I cannot support legislation that would result in the loss of health insurance coverage for a population the size covered in the combined states of Vermont, Delaware, South Dakota, and Wyoming.

Fortunately, we can provide the key protections that consumers want at a minimal cost and without disruption of coverage—if we apply these protections responsibly and where they are needed.

In sharp contrast to the Democratic alternative, our bill would actually increase coverage. With the additional of the Tax Code provisions to S. 326, the Patients' Bill of Rights Act, our bill allows for the full deduction of health insurance for the self-employed, the full availability of medical savings accounts and the carryover of unused benefits from flexible spending accounts. With the new Patients' Bill of Rights Plus Act we provide Americans with greater choice to more affordable health insurance.

S. 326, the Patients' Bill of Rights Act, provides necessary consumer protections without adding significant new costs; without increasing litigation; and without micro-managing health plans.

I also point out that under the law a doctor is still open to suit. Although they are prescribed health plans, the doctors are liable.

Our goal is to give Americans the protections they want and need in a package that they can afford and that we can enact.

This is why I hope the Patients' Bill of Rights that we are offering today will be enacted and signed into law by the President.

I believe very strongly that the advantages we get, especially that we require, the standard of best medicine, and not just the medicine that is generally used in the area is by far a much better protection for the people we are trying to protect—the patients—than the Democrat's Patient's Bill of Rights.

Mr. President, I yield the floor.

EXHIBIT 1

GENERAL ACCOUNTING OFFICE,
HEALTH, EDUCATION AND HUMAN SERVICES DIVISION,
Washington, DC, July 7, 1998.

Subject: Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals Is Uncertain

Hon. JAMES M. JEFFORDS,
Chairman, Committee on Labor and Human Resources, U.S. Senate.

DEAR MR. CHAIRMAN: Almost 150 million individuals obtained health insurance through the workplace in 1996, either through their own employment or the employment of a family member. During the last several years, an increasing number of individuals with employer-sponsored insurance have enrolled in some form of managed care rather than in fee-for-service plans. Recently, concerns have grown regarding the ways in which some managed care plans operate and the adequacy of information shared between each plan, its providers, and its members.

In response to these concerns, several legislative proposals have been made to require health insurance plans to adopt specified operational practices. The proposals apply to all types of plans, but would likely have their greatest impact on health maintenance organizations (HMO). Other types of plans, such as preferred provider organizations (PPO) and indemnity, or fee-for-service, plans, will likely be affected to a lesser degree. Included in various proposals are requirements, for example, to disclose certain information,[1] guarantee patient access to emergency and specialty services, implement internal and external grievance policies, guarantee freedom of communication between providers and patients, and eliminate the Employee Retirement Income Security Act of 1974 (ERISA) restrictions on health plan liability.

However, some lawmakers are concerned that these types of mandates could increase the cost of health insurance and have the unintended consequence of reducing the number of individuals covered by private health insurance.

This letter responds to your request for information on the relationship between the amount charged for private health insurance and the number of insured individuals. You also asked us to analyze the basis for a widely cited statistic from the Lewin Group, a private research and consulting organization, that the number of insured individuals

[1] Footnotes at end of Report. (Figure not reproducible in RECORD.)

would fall by 400,000 for every 1-percent increase in health insurance premiums. Specifically, we (1) examined the trends in employers' decisions to offer insurance and employees' decisions to purchase it, (2) assessed the methodology used by the Lewin Group to support its 400,000 coverage loss estimate, (3) assessed the methodology used by the Lewin Group to produce its most recent estimates, and (4) evaluated conditions or factors that could affect the impact of premium increases on insurance coverage. To conduct our study, we reviewed relevant published research. We also evaluated the applicability of the Lewin Group's estimates given the data, methods, and assumptions it used to produce its estimates. We performed our work between May 1998 and June 1998 in accordance with generally accepted government auditing standards.

In summary, during a period of rising health insurance premiums, the proportion of employees offered coverage rose, while the share that accepted insurance fell. Between 1988 and 1996, health insurance premiums increased, on average, by approximately 8 percent per year.[2] During roughly the same period, 1987 to 1996, the proportion of workers who were offered insurance by their employers rose from 72.4 percent to 75.4 percent, according to one recent study.[3] The same study found that the proportion of workers who accepted coverage, however, fell from 88.3 percent to 80.1 percent. This may be because employers required employees to pay a larger share of the premiums.[4] In 1988, employees in small firms (fewer than 200 workers) paid an average of 12 percent of single-coverage premiums. Employees in large firms paid about 13 percent.[5] By 1996, the employee share had risen to 33 percent in small firms and 22 percent in large firms. Other factors, such as decreases in some workers' real incomes, Medicaid-eligibility expansions, and changes in benefit generosity, also may have contributed to the fall in the acceptance rate.

In November, 1997, the Lewin Group used published studies to estimate that 400,000 fewer individuals would have health insurance coverage for every 1 percent increase in insurance premiums.[6] Several of these studies had sought to quantify the impact of subsidized insurance premiums on the increase in the number of employers offering insurance. The Lewin Group concluded from these studies that a 1-percent decrease in premiums would likely induce an additional 0.4 percent of employers to offer insurance. It then assumed that an increase in premiums might cause a similar percentage of firms to drop health insurance coverage and cause 400,000 individuals to be without coverage. The findings of more recent studies, however, call into question the basis for the Lewin Group's estimate. Although these studies did not quantify the relationship between premium increases and changes in the number of employees with coverage, they clearly show that employers generally continued to offer insurance during a period of rising premiums but that fewer employees decided to purchase coverage. The estimate also assumes equal premium increases for all types of insurance products. If new federal mandates primarily affect HMO premiums, some employees may switch to other types of insurance—especially insurance with different benefit packages—instead of dropping coverage entirely. Thus, the Lewin Group's estimate may not be a good predictor of the coverage loss that might be caused by new federal mandates.

In January 1998, the Lewin Group lowered its estimate of potential coverage losses by about 25 percent.[7] It now estimates that a 1-percent premium increase could result in approximately 300,000 fewer individuals being covered by private insurance. The new estimate is based on the Lewin Group's statistical analysis of the relationship between how much employees pay for insurance and the probability that they, their spouses, and their dependent children have employer-sponsored health insurance. However, it is unclear how accurately the Lewin Group was able to measure the price paid by the individuals in its sample. Moreover, the new estimate applies to situations in which premiums for all insurance types increase, on average, by 1 percent. If premiums increase by 1 percent only for some insurance types (for example, HMOs), then the coverage loss predicted by the Lewin Group would be less than 300,000.

Because many factors can affect the number of individuals covered by private insurance, it is difficult to predict the impact of an increase in insurance premiums. For example, new mandates may increase premiums but may also change individuals' willingness to purchase insurance. Individuals may not mind paying higher premiums if they like the changes brought about by the mandates. The extent to which employers pass on premium increases to employees also can affect coverage by influencing employees' purchasing decisions. Another important determinant is the extent to which employees switch from plans with high premium increases to plans with no or low premium increases, or to less expensive plans with more limited benefits. Finally, changes in other economic factors, such as income, or changes in public insurance program eligibility requirements can affect the number of individuals with private health insurance.

BACKGROUND

Between 1995 and 1997, real health insurance premiums (adjusted for inflation) remained nearly constant or fell slightly across all plan types. (See table 1.) This represents a sharp decline from the previous 5 years, in which inflation-adjusted growth was as high as 11.6 percent for indemnity plans and 10.6 percent for HMO plans in 1990.

TABLE 1.—PERCENTAGE OF REAL ANNUAL GROWTH IN PREMIUMS BY TYPE OF HEALTH PLAN, 1990–97

Plan type	1990	1991	1992	1993	1994	1995	1996	1997
Indemnity	11.6	7.8	8.0	5.5	2.5	−0.1	−1.8	0.3
PPO	9.6	5.9	7.6	5.2	0.6	0.7	−2.4	−0.2
HMO	10.6	7.9	6.8	5.3	2.7	−2.4	−3.4	−0.3

Sources: GAO calculations based on data from KPMG Peat Marwick (1991–97); Health Insurance Association of America (1990), and Bureau of Labor Statistics Consumer Price Index. Includes employer and employee shares of premiums for workers in private firms with at least 200 employees.

About 70 percent of the population under age 65 was covered by health insurance purchased through an employer or union, or purchased privately as an individual in 1996, according to Current Population Survey (CPS) data. About 12 percent was covered by Medicare, Medicaid, or the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and about 18 percent was uninsured. From 1989 to 1996, the percentage of the population covered by employer-sponsored, union-sponsored, or individual insurance[8] decreased slightly, but these options still remained a dominant source of coverage for people under age 65. (See fig. 1.) During the same period, the proportion of the population covered by Medicaid and the proportion without insurance both increased.

MORE WORKERS WERE OFFERED INSURANCE, BUT FEWER ACCEPTED COVERAGE AS PREMIUMS INCREASED

Recent studies suggest that employers typically do not stop offering health insurance when premiums increase. Between 1988 and 1996, health insurance premiums—unadjusted for inflation—increased by about 8 percent per year, on average. During approximately the same time period, one study[9] found that the fraction of workers offered insurance by their employers grew slightly, from 72.4 percent to 75.4 percent. The proportion of workers who had access to employer-sponsored insurance, either through their own job or the job of a family member, remained essentially constant at about 82 percent. Another study[10] reported that the fraction of small firms (those with fewer than 200 employees) offering insurance coverage grew from 46 percent in 1989 to 49 percent in 1996. The study also found that 99 percent of large firms offered insurance in 1996.

Fewer workers, however, are choosing to accept employer-sponsored coverage for themselves or their dependents. In 1987, 88.3 percent of workers accepted coverage when their employers offered it. In 1996, only 80.1 percent of workers accepted coverage. The fall in the acceptance rate was relatively large for workers under age 25 (from 86.5 percent to 70.1 percent) and those making $7 per hour or less (from 79.7 percent to 63.2 percent). The fraction of workers who accepted employer-sponsored insurance either through their own job or that of a family member also declined, from 93.2 percent to 89.1 percent. Consequently, even though a greater percentage of employers offered insurance, the acceptance rate fell to such an extent that a smaller proportion of workers was covered by employer-sponsored insurance in 1996 compared with 1997.

The fall in the acceptance rate may be attributable partly to required increases in employees' insurance premium contributions. One study found that employees in small firms paid an average of 12 percent of single coverage premiums in 1988 and employees in large firms paid 13 percent.[11] In 1996, the employee share had risen to 33 percent in small firms and 22 percent in large firms. According to the Lewin Group, the combined effect of the increase in premiums and the increase in the employees' share of those premiums resulted in workers paying 189 percent more in real terms for single coverage and 85 percent more in real terms for family coverage in 1996 compared with 1988.

Other factors also may have contributed to the drop in the acceptance rate. A decline in real wages for some workers may have made coverage less affordable. Expansions in Medicaid eligibility provided a coverage alternative for some families and may have decreased workers' willingness to accept employer-sponsored insurance. Furthermore,

possible changes in benefit packages may have made coverage less desirable.

LEWIN ESTIMATE OF 400,000 COVERAGE LOSS BASED ON OUTDATED STUDIES

In November 1997,[12] the Lewin Group estimated that 400,000 fewer people might be covered by health insurance if new legislation caused premiums to rise by 1 percent. Its estimate was largely based on studies of the effects of insurance premium subsidies on employers' decisions to offer insurance. However, recent research casts doubt on the applicability of these findings to other situations. Furthermore, according to the Barents Group, a research and consulting firm, the Lewin Group's coverage loss estimate may be too high because some individuals may switch to other types of health plans if new legislation causes HMO premiums to rise.

Few studies have analyzed the relationship between the cost of insurance and the number of individuals covered. The studies available to Lewin in November 1997 primarily focused on employers' decisions to offer insurance. These studies varied widely both in their research questions and their findings. Several studies[13] examined the effects of programs designed to increase coverage by subsidizing the premiums paid by employers—particularly small ones. The estimates from this group of studies varied, with one suggesting that between 0.07 percent and 0.33 percent of small firms might begin to offer insurance if premiums were reduced by about 1 percent. Some older studies, using data from 1971 and before, found that between 0.6 percent and 2 percent of firms might stop offering health insurance coverage if premiums increased by 1 percent.

The Lewin Group selected a range of estimates, from what it judged to be the best available, to predict that between 0.2 percent and 0.6 percent of firms would stop offering coverage if insurance premiums increased by 1 percent. It then selected the midpoint of this range (0.4 percent) as its best estimate. To calculate the potential impact on coverage, the Lewin Group multiplied 150 million—the number of workers and their dependents covered by employer-sponsored health plans in 1996—by 0.004—the percentage of firms expected to drop coverage.[14] This calculation suggested that 600,000 individuals would lose employer-sponsored health insurance if premiums increased by 1 percent. However, on the basis of its analysis of CPS data, the Lewin Group assumed that about one-third (or 200,000) of these 600,000 workers would obtain insurance either through the policies of working family members, the individual insurance market, or public insurance programs.[15] Consequently, it estimated that a 1-percent premium increase might result in a drop in coverage of about 400,000 individuals.

The Lewin Group's estimated potential coverage loss does not consider the possibility that employers or employees might switch to different types of insurance products if one type becomes relatively more expensive. This is important in the current context because many of the proposed federal mandates are expected primarily to affect HMOs and have little or no impact on PPOs and indemnity plans. The Barents Group, a private research and consulting organization, recently reported on the potential coverage loss that proposed mandates could cause.[16] The Barents Group used the Lewin coverage loss estimate but reduced it by 25 percent to allow for the possibility that some employees might switch from HMOs to other types of insurance plans instead of dropping coverage altogether.

CURRENT LEWIN GROUP COVERAGE LOSS ESTIMATE LOWER BY 25 PERCENT

Recent data analysis by the Lewin Group led it to revise its estimate of potential coverage loss. The Lewin Group now projects a loss of employer-sponsored coverage of approximately 300,000 people for every one percent increase in premiums. This estimate, reported in January 1998, is approximately 25 percent lower than its November 1997 estimate. The new estimate is based on the Lewin Group's statistical analysis of the relationship between what employees pay for insurance and the probability that they, their spouses, and their dependent children have employer-sponsored health insurance.[17]

A key variable in the January 1998 Lewin Group study is the price of insurance, but because of data limitations, this was measured imperfectly. The study primarily used CPS data from 1989 to 1996. CPS data, however, do not contain information on health insurance premium amounts. Lewin, therefore, used three data sources to impute the amount employees paid for insurance:[18] the 1987 National Medical Expenditure Surveys (NMES), the KPMG Peat Merwick employer surveys for 1991 through 1996, and the Health Insurance Association of America (HIAA) employer surveys for 1988 through 1990. The authors of the Lewis report acknowledged that these surveys were not strictly comparable, and that the information used to measure the employee share of health insurance may have been different for 1988 through 1990 than for 1991 throgh 1996. Another potential shortcoming related to premium amounts is that the analysis did not allow for the possibility that some workers may decline coverage from their own employers when they can obtain it through a family members' employer-based coverage.

The Lewin Group's estimate is of the coverage decline that would result from an overall average premium increase of 1 percent. Yet, the proposed federal mandates are expected primarily to affect HMOs. If HMOs' premiums rise by 1 percent, then premiums for other types of insurance would probably not increase as much. HMO enrollees, therefore, would be affected most by the premium increases. Under these circumstances, the Lewin Group's estimate could overstate the coverage decline.

The Lewin Group explicitly assumed that all observed coverage changes were due to employees' decisions.[19] Consequently, it used the imputed employee contribution as the relevant cost of insurance. This assumption is broadly supported by the recent literature. However, if some employees lost access to insurance because of their employers' decisions to no longer offer it, the Lewin Group's estimate may incorrectly predict employees' reactions to changes in premiums.

POTENTIAL COVERAGE LOSS UNCERTAIN, DEPENDS ON MANY FACTORS

Insufficient information is currently available to predict accurately the coverage loss that may result from health insurance premium increases associated with new federal mandates. One problem is that the potential cost of the mandates and their impact on premiums is not yet known. However, even if the premium increase was known with certainty, previous research and economic theory suggest that the impact on coverage depends on a number of conditions. Coverage changes will depend on the extent to which premiums rise for employees and whether they can switch to insurance plans less affected by the mandates. The specific policy adopted also can affect how employees respond to resulting premium increases. Finally, changes in many economic and other factors can cause coverage changes that mask or exaggerate the impact of premium increases. The following list describes several conditions that could affect observed changes in health insurance coverage if new federal mandates increase insurance costs.

1. The percentage of premiums paid by employees and the amount of any premium increase the employers pass on to employees. If, as recent evidence suggests, employees' decisions largely affect the extent of coverage, then the relevant price increase is the percentage increase in their contribution. For example, about two-thirds of employees in small firms had to contribute toward premium costs in 1996. Those employees paid about 50 percent of the total premium. If total premiums rise by 1 percent and employers pass on the full increase to employees, then the employees' contribution would rise by 2 percent.

2. The extent to which additional benefits are valued by consumers. If higher insurance premiums are the result of additional benefits that consumers value, then any coverage loss will be less than the coverage loss that might occur if premiums increased but benefits stayed the same (or the additional benefits had little consumer value). In its November 1997 letter, the Lewin Group notes that its ''estimates of the number of persons losing coverage will differ depending upon the health policy being analyzed.'' The Lewin Group goes on to suggest that ''some proposals that increase premium costs are often associated with other provisions that may either lessen or intensify incentives for individuals to drop coverage.''

3. The extent to which some types of plans have no or low premium increases and employees can switch to them. Proposed new federal mandates are expected primarily to increase costs of HMOs. Faced with a rise in HMO premiums, some employees may switch to PPOs or indemnity insurance rather than drop coverage entirely. The Barents Group assumed this switching behavior might lower the Lewin Group's coverage loss estimate by 25 percent.

4. Changes in other insurance benefits. Instead of raising premiums in response to new mandated benefits, insurance companies and employers may find ways to reduce other parts of the insurance package to keep premiums constant. It is unknown how employees might respond to such changes in their insurance plans.

5. Changes in real wages and other factors. Changes in economic conditions or eligibility for public insurance programs can also affect private insurance coverage. For example, the Lewin Group estimated that a 1-percent rise in real incomes could increase private insurance coverage by nearly 0.37 percent (about 550,000 workers and dependents). Likewise, expansions in Medicaid eligibility could cause some workers to substitute public insurance for employer-sponsored family coverage.

COMMENTS FROM THE LEWIN GROUP

In commenting on a draft of this correspondence, a representative of the Lewin Group said that we had accurately characterized its analysis and findings. The representative suggested one technical clarification in our report's characterization of the Lewin Group study that we adopted.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution until 30 days from the date of this letter. We will then make copies available to others who are interested.

Please call me or James Cosgrove, Assistant Director, if you or your staff have any

questions. Susanne Seagrave also contributed to this letter.

Sincerely yours,

WILLIAM J. SCANLON,
Director, Health Financing and Systems Issues.

FOOTNOTES

[1] Legislative proposals would require each plan to disclose, for example, information on appeal procedures, restrictions on reimbursement for care received outside of the plan's network of providers, and the location of plan providers and facilities.

[2] J. Gabel, P. Ginsburg, and K. Hunt, ''Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence,'' *Health Affairs*, 16(5) (Sept./Oct. 1997). J. Sheils, P. Hogan, and N. Manolov, ''Exploring the Determinants of Employer Health Insurance Coverage,'' report to the AFL–CIO (Fairfax, Va.: The Lewin Group, Inc., Jan. 20, 1998).

[3] P. Cooper and B. Schone, ''More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996,'' *Health Affairs*, 16(6) (Nov./Dec. 1997), pp. 142–49.

[4] *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures* (GAO/HEHS–97–122, July 24, 1997).

[5] J. Gabel, P. Ginsburg, and K. Hunt, ''Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence,'' *Health Affairs*, 16(5) (Sept./Oct. 1997), pp. 103–10.

[6] John F. Sheils, Vice President, The Lewin Group, letter to Richard Smith, American Association of Health Plans, Nov. 17, 1997.

[7] J. Sheils, P. Hogan, and N. Manolov, *Exploring the Determinants of Employer Health Insurance Coverage*, report to the AFL–CIO (Fairfax, Va: The Lewin Group, Inc., Jan. 20, 1998).

[8] Individual insurance is coverage that an individual purchases directly from an insurer or through a broker.

[9] See P. Cooper and B. Schone, ''More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996,'' p. 144.

[10] See P. Ginsburg, J. Gabel, and K. Hunt, ''Tracking Small-Firm Coverage, 1989–1996,'' p. 168.

[11] J. Gabel, P. Ginsburg, and K. Hunt, ''Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence,'' p. 107.

[12] John F. Sheils letter to Richard Smith, Nov. 17, 1997.

[13] See K. Thorpe, and others, ''Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results From a Pilot Study,'' *The Journal of the American Medical Association*, 267(7) (1992), pp. 945–48; Statement of Nancy L. Barrand and W. David Helms for the Robert Wood Johnson Foundation, before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, *Health Insurance Options: Reform of Private Health Insurance* (Washington, DC: May 23, 1991), pp. 125–61. W. Helms, A. Gauthier, and D. Campion, ''Mending the Flaws in the Small-Group Market,'' *Health Affairs* (Summer 1992), pp. 7–27; C. McLaughlin and W. Zellers, ''The Shortcomings of Voluntarism in the Small-Group Insurance Market,'' *Health Affairs* (Summer 1992), pp. 28–40; J. Gruber and J. Poterba, ''Tax Subsidies to Employer-Provided Health Insurance,'' Working Paper No. 5147, Cambridge, Mass.: National Bureau of Economic Research, June 1995.

[14] The studies' findings applied to the percentage of firms that might change their behavior. The Lewin Group, however, applied this percentage to individuals. This implicitly assumes that all sizes of firms would react similarly. If large firms are less responsive to premium increases than small firms, then the percentage of workers affected by a 1-percent increase in premiums could be less than 0.4 percent.

[15] Lewin's November 1997 letter did not discuss how many of the 200,000 individuals might enroll in public insurance programs and how many might obtain other private coverage.

[16] *Impact of Legislation Affecting Managed Care Consumers: 1999–2003*, report for the American Association of Health Plans (Washington, DC: The Barents Group, LLC, Apr. 21, 1998).

[17] Lewin used complex statistical models to estimate the proportion of the population covered by employer-sponsored insurance grouped by a number of demographic characteristics, including race, age, income, full-time/part-time status, occupation, industry, firm size, and the imputed employee share of the premium costs, among others.

[18] Lewin focused on the employee share of the insurance premium as the most appropriate cost affecting the employee decision to participate in employer-sponsored health plans.

[19] The data used in the Lewin study do not indicate whether observed coverage losses are the result of employers' decisions not to offer insurance or employees' decisions not to accept it.

Mr. JEFFORDS. Mr. President, the GAO report examines two reports done by the Lewin Group on the impact of premium increases on coverage.

A 1997 report by Lewin indicates that a 1% increase will result in 400,000 losing coverage.

A 1998 report by Lewin for the AFL/CIO indicates that a 1% increase will result in 300,000 Americans losing coverage. It is this lower number that I used.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I will just take a moment.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, with regard to just one fact that the Senator has mentioned, I have the GAO report to which the Senator refers. The fact that the Senator refers and is talking about is on page 4 of the report. It says:

If premiums increase by 1 percent only for some insurance types (for example, HMOs), then the coverage loss predicted by the Lewin Group to . . .

Not the GAO, it is the Lewin Group that makes the estimate referred to in the GAO letter.

To the contrary, if you read on, GAO says:

Because many factors can affect the number of individuals covered by private insurance, it is difficult to predict the impact of an increase in insurance premiums. For example, new mandates may increase premiums but may also change individuals' willingness to purchase insurance.

Therefore, there might be more people covered.

This is the kind of thing we ought to be debating out here. This is just the type of thing we ought to be debating. We have a lot of distortions and misrepresentations. The insurance companies themselves have spent $100 million in distorting our proposal. What we want to do is to try to clarify the RECORD on this.

Mr. DURBIN. Will the Senator yield?

Mr. KENNEDY. If I could just mention one other point, the Senator talked about what we wanted to do last year with regard to the Patients' Bill of Rights.

I have in my hand the majority leader's unanimous consent request. Here it is. This is an offer from last June 18, a little over a year ago, when we were trying to bring this legislation up.

I ask unanimous consent that prior to the August recess . . .

Isn't that interesting? June of last year; they are saying ''prior to the August recess.''

. . . the majority leader after notifying the minority leader shall turn to the consideration of the bill to be introduced by the majority leader . . .

It doesn't tell us what that is going to be.

. . . or his designee regarding health care. I further ask that the Senate proceed to its immediate consideration.

And following the report by the clerk that Senator DASCHLE be recognized to offer as a substitute the text of S. 1891, which really wasn't the all-inclusive legislation, the majority leader is trying to tell the Democratic leader which bill he ought to put in.

I further ask that during the consideration of the health care legislation it be in order for Members to offer health care amendments in the first and second degree. I further ask consent that the Chair not enter a motion to adjourn or recess for the August recess prior to a vote or in relation to the majority leader's bill and the minority leader's amendment, and following those votes it be in order for the majority leader return to the legislation to the calendar.

To the calendar—not send it over to the House of Representatives—to the calendar.

Let's be clear about who is serious about bringing this up. Here is their consent request. They are going to return it to the calendar. Even if we win the vote, under their proposal, that could be the end of it.

Then it says:

Finally, I ask consent that it not be in order to offer any legislation, motion, or amendment relative to health care prior to the initiation of this agreement and following the execution of the agreement.

Therefore, you can't offer a health care measure for the rest of the Congress.

If the Senator from Vermont can say with a straight face that it is the Democrats who are trying to lock this thing up when the Senator has his own leader making a proposal like this, he is defying any kind of rational understanding of what a unanimous consent rule is.

Mr. DURBIN. Will the Senator yield for a question?

Mr. KENNEDY. I would be glad to yield for a question.

Mr. DURBIN. I am going to ask a very brief question. Is it not true that at 5:45—in 45 minutes—there will be a motion by the Republicans to table the Democratic version of the Patients' Bill of Rights without further debate, without further amendment, and to bring to an end this debate about whether families across America will have the stronger voice in terms of their health insurance protection?

I ask the Senator from Massachusetts, who has been here for a few months, to respond, if he will. Why is it that the Republican majority is so concerned about or afraid of the idea of actually debating or deliberating something which is so important to American families, their health care?

Mr. KENNEDY. We will have to listen to the explanation coming from the

other side. We know what the spokesman for the health insurance industry has said. We know what their answer has been, and that is to virtually instruct the Republican leadership just to say no. We know what the leadership on the other side has said about this: We are not going to get a chance to debate this issue.

People can draw their own conclusions. They have indicated this will not be permitted to come up, even though it is the people's business.

I see the Senator from Rhode Island on the floor. I yield 5 minutes.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator from Rhode Island.

Mr. REED. Mr. President, as I look at the Republican proposals, they are deficient in many ways. Of particular concern to me is the way this proposal mistreats children.

The Democratic proposal, the proposal we would like to not only debate but also to vote on, emphasizes the need to protect the children of America. I hope we all can agree that at the end of this Congress at least we can provide adequate protections in managed care for children.

Don't just take my word for it. Take the word of organizations including the American Academy of Pediatrics, the American Association of Children's Residential Centers, the American Academy of Child and Adolescent Psychiatry, the Children's Defense Fund, the Child Welfare League of America. All of these organizations support unequivocally the Democratic Patients' Bill of Rights. This is the legislation we know and they know will protect the children of America.

There are three key points that are terribly important with respect to the differences between the Republican proposal and the Democratic proposal.

First, our legislation will assure access to pediatric specialists. In the world of medicine today, it is not just sufficient to visit an oncologist if you have cancer and you are a child, because pediatric oncology is a particular specialty that is necessary for children who have serious cancers.

Second, our legislation provides clearly expedited review procedures if child development is threatened—not just their life but their development. This is a critical issue that is virtually unique to children. This is something we have to protect and ensure.

Third, we also have provisions within our legislation that will measure outcomes in terms of children, so that when parents are trying to determine what plan is best for their child, they can actually look at measured results: How well this particular plan did—not with a large population of adults, but particularly with respect to children.

The Republican plan has some fuzzy language regarding pediatricians and specialists.

Clearly and unequivocally, there is language in the Democratic legislation that guarantees children access to providers who are trained to take care of them, access to pediatric specialists, expedited review procedures in the case of developmental difficulties for children, and also outcome measures that actually take children into consideration. These are critical issues that have to be included in any managed care legislation we pass on the floor of the Senate.

What did the American people think about that? I have listed August organizations like the American Academy of Pediatrics in support of this measure. Let me tell Members what the American people think.

In February of 1999, a survey by Lake Sosin Snell Perry and Associates and the Tarrance Group—one a Democratic polling firm, the other a Republican polling firm—revealed 86 percent of voters surveyed favored having Congress require health plans to provide children with access to pediatric specialists and hospitals that specialize in treating children.

That is an overwhelming example of what the American people are asking: Protect their children, and give them access to pediatric specialists. Let them choose, as mothers and fathers, pediatricians to be primary care providers for their sons and daughters.

Not only do the American people demand these provisions, they will also pay for them. Seventy-six percent of the voters surveyed said they would pay for these protections, ''even if it increased health insurance costs for families with children by $100 a year.''

They want these protections. Only the Democratic version gives them these protections.

Mr. NICKLES. I yield myself a couple of minutes, and then I will yield to my colleague from Maine.

Our colleague from Massachusetts said there was a unanimous consent request last year; we were talking about doing this last June and July. That is correct. We offered several unanimous consent requests, from June 18, July 15, and July 25, to bring this bill up to allow both sides to have a chance to vote on their proposals. We offered a number of amendments before the August break. Those were not agreed upon.

Everyone has had a chance to offer their bill and to have it voted on. We would have a package, we would have a bill, before the Senate that possibly could pass. That was not agreed upon last year. I don't know if it will be agreed upon this year. I told the Democratic sponsors we are willing to come to some time agreement, some limit on amendments, but we are not just going to have the bill on the floor for an unlimited number of amendments with unlimited debate.

Somebody asked, Why haven't we done this?

The Kennedy bill increased health care costs a lot. It is estimated that health care costs will increase 4.8 percent in addition to whatever health care increases are already scheduled. Increases are scheduled to be 7 to 9 percent. Take the average of that, 8 percent, and add 4.8 percent. That is a 13-percent increase in health care costs. That will increase the number of uninsured by at least 1.5 million.

I am going to work energetically to see we don't pass any bill that increases people's health care costs by 13 percent in 1 year. Certainly, I will work energetically to see we don't pass a health care bill that increases the number of uninsured by 1.5 million. That would be a serious mistake.

Whatever the Senate does, it should do no harm. If we increase health care costs in double digits and increase the number of uninsured by over a million, we have done a lot of harm. Some Members will not do that.

We should make some needed reforms. One of my colleagues worked energetically to put together a good package that makes needed reforms.

I yield 7 minutes to our colleague from Maine, Senator COLLINS.

Ms. COLLINS. Mr. President, there is growing unease across this Nation about the changes in how we receive our health care, which has prompted the current debate on managed care. People worry, if they or their loved ones become ill, that their HMO may deny them coverage and force them to accept either inadequate care or financial ruin—or perhaps even both. They believe vital decisions affecting their lives will be made not by a supportive family doctor but by an unfeeling bureaucracy.

All Members agree that medically necessary patient care should never be sacrificed to the bottom line and that health care decisions should be in the hands of medical professionals, not in the hands of insurance accountants.

We do, however, face an extremely delicate balancing act as we attempt to respond to concerns without resorting to unduly burdensome Federal controls and mandates that will further drive up the costs of health insurance and cause some people to lose their coverage altogether. That is the crux of this entire debate.

I am very alarmed by recent reports that American employers everywhere, from giant multinational corporations to the small corner store, are facing huge hikes in their medical insurance coverage for their employees, averaging over 8 percent, and sometimes soaring to 20 percent or more. This is a remarkable contrast to the past few years when premiums rose less than 3 percent, if at all.

We know for a fact that increasing health insurance premiums cause significant losses in coverage. That is the primary reason why I am so opposed to

the approach offered by the Senator from Massachusetts. Even if we discard CBO's previous estimate that the Kennedy bill would increase premiums by 6.1 percent and accept the newly revised estimate of 4.8 percent, the fact is the CBO score for the Democratic bill is six times higher than the cost for the bill we are proposing.

Moreover, the Lewin Associates, in a study for the AFL–CIO, has estimated that for every 1-percent increase in premiums, we are jeopardizing the insurance coverage of as many as 300,000 Americans. Based on these projections, the passage of the Kennedy legislation could result in the loss of coverage for more than 1.4 million Americans. That is more than the population of the entire State of Maine. This is a significant cost.

If you look at the CBO estimate of the revised Kennedy bill, CBO estimates it will impose additional costs to the private sector of nearly $41 billion over the next 5 years. That is a cost that is going to cause employers to drop insurance altogether or employees to be unable to pay their share of the premium. At a time when the number of uninsured Americans, unfortunately, is increasing with every year, we should be acting to decrease the number of uninsured Americans, not impose costly new burdens that are going to cause some of the most vulnerable working Americans to lose their coverage altogether.

Our approach, on the other hand, provides the key protections that consumers need and want without causing costs to soar. It applies these protections responsibly, where they are needed. Our legislation does not preempt, but rather builds upon the good work the States have done in the area of patients' rights and protections. States have had the primary responsibility for the regulation of health insurance since the 1940s. As someone who has worked in State government for 5 years overseeing a Bureau of Insurance, I know State regulators and State legislators have done an excellent job of responding to the needs and concerns of their citizens.

Let me give you just a few examples. Mr. President, 47 States have already passed laws prohibiting gag clauses that restrict communications between patients and their doctors; 40 States have requirements for emergency care; all 50 States have requirements for grievance procedures; 36 require direct access to an obstetrician or a gynecologist.

The States have acted, without any prod or mandate from Washington, to protect health care consumers. That is why the National Association of Insurance Commissioners supports the approach we have taken in our bill.

In a March letter to the chairman of the Committee on Health, Education, Labor, and Pensions, the NAIC pointed out:

> It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

That is exactly the approach we have taken. Currently, Federal law prohibits States from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans. Our legislation is intended to protect the unprotected. We would extend many of the same rights and protections to these consumers and their families that those in State-regulated plans already enjoy.

For the first time they will be guaranteed the right to talk freely and openly with their doctors about their treatment options. We would ban the gag clauses. They will be guaranteed coverage for emergency room care that a ''prudent layperson'' would deem medically necessary without prior authorization. They will be able to see a pediatrician or an OB/GYN without a referral from their plan's ''gatekeeper.'' They will have the option of seeing a doctor who is not part of the HMO's network. They will be guaranteed access to nonformulary drugs when it is medically necessary. They will have an assurance of continuity of care if their health plan terminates its contract with their doctor or hospital.

The opponents of our legislation contend that the Federal Government should simply preempt the States' patient protection laws unless they are virtually identical to what the Federal Government would require. But the States' approaches to these patient protections vary widely. For example, States may have emergency requirements, but not exactly the same standard that the Democrats in Senator KENNEDY's bill would impose on everyone. States that have already acted in this area would have to make extensive changes to their laws, if they are forced to comply with the one-size-fits-all model.

Moreover, what if the State has made an affirmative decision not to act in one of these areas? What if the bill failed in the legislature or was vetoed by the Governor? Let me give you a recent example from my State. Maine law requires plans to allow direct access to ob/gyn care—without a referral from the primary care physician—but only for an annual visit. Maine also requires plans to allow ob/gyns to serve as the primary care provider. Our State Legislature recently decided that the current provisions provide sufficient protection and rejected a bill that would have expanded the direct access provision, primarily out of concern that it would drive up premium costs. I would note that this decision was made by a legislature controlled by the Democratic Party. In cases like these, the Kennedy proposal for a one-size-fits-all model would be a clear preemption of State authority.

Other provisions of our bill provide new protections for millions more Americans. A key provision of our bill builds upon the existing regulatory framework under ERISA to give all 124 million Americans in employer-sponsored plans assurance that they will get the care that they need when they need it. The legislation will enhance current ERISA information disclosure requirements and penalties and strengthen existing requirements for coverage determinations, grievances and appeals, including the addition of a new requirement for independent, external review.

All 124 million Americans in employer-sponsored plans will be entitled to clear and complete information about their health plan—about what it covers and does not cover, about any cost-sharing requirements, and about the plan's providers. Helping patients understand their coverage before they need to use it will help to avoid coverage disputes later.

The goal of any patients' rights legislation should be to resolve disputes about coverage up front, when the care is needed, not months or even years later in a court room.

Our bill would accomplish this goal by creating a strong internal and an independent external review process. First, patients or doctors who are unhappy with an HMO's decision could appeal it internally through a review conducted by individuals with ''appropriate expertise'' who were not involved in the initial decision. Moreover, this review would have to be conducted by a physician if the denial is based on a determination that the service is not medically necessary or is an experimental treatment. Patients could expect results from this review within 30 days, or 72 hours in cases when delay poses a serious risk to the patient's life or health.

Patients turned down by this internal review would then have the right to a free, external review by medical experts who are completely independent of the health plan. This review must be completed within 30 days—and even faster in a medical emergency or when the delay would be detrimental to the patient's health. Moreover, the decision of these outside reviewers is binding on the health plan, but not on the patient. If the patient is not satisfied, he or she retains the right to sue in federal or state court for attorneys' fees, court costs, the value of the benefit and injunctive relief.

Our bill places treatment decisions in the hands of doctors, not lawyers. If your HMO denies you treatment that your doctor believes is medically necessary, you should not have to resort to a costly and lengthy court battle to get the care you need. You should not have to hire a lawyer and file an expensive lawsuit to get the treatment.

Our approach contrasts with the approach taken in the measure offered by Senators DASCHLE and KENNEDY that would encourage patients to sue health plans. I do not support Senator KENNEDY's approach. You just can't sue your way to quality health care.

We would solve problems up front, when the care is needed, not months or even years later after the harm has occurred. According to the GAO, it takes an average of 33 months to resolve malpractice cases. This does nothing to ensure a patient's right to timely and appropriate care. Moreover, patients only receive 43 cents out of every dollar awarded in malpractice cases. The rest winds up in the pockets of trial lawyers and administrators of the court and insurance systems.

I met with a group of Maine employers who expressed their serious concerns about the Kennedy proposal to expand liability for health plans and employers. The Assistant Director for Human Resources at Bowdoin College talked about how moving to a self-funded, ERISA plan enabled them to continue to offer affordable coverage to Bowdoin employees when premiums for their fully-insured plan skyrocketed in the late 1980s. Since they self-funded, they have actually been able to lower premiums for their employees, while, at the same time, enhance their benefit package with such features as well-baby care, free annual physicals, and prescription drug cards with low copayments. They told me that the Democrats' proposal to expand liability seriously jeopardizes their ability to offer affordable coverage for their employees. Similar concerns were expressed by the Maine Municipal Association, L.L. Bean, Bath Iron Works, and other responsible Maine employers.

And finally, our amendment will make health insurance more affordable by allowing self-employed individuals to deduct the full amount of their health care premiums. Establishing parity in the tax treatment of health insurance costs between the self-employed and those working for large businesses is a matter of basic equity, and it will also help to reduce the number of uninsured, but working, Americans. It will make health insurance more affordable for the 82,000 people in Maine who are self-employed. They include our lobstermen, our hairdressers, our electricians, our plumbers, and the many owners of mom-and-pop stores that dot communities throughout my state.

Mr. President, I believe that this amendments strikes the right balance as we effectively address concerns about quality and choice without resorting to unduly burdensome federal controls and mandates that will further drive up costs and cause some Americans to lose their health insurance altogether, and I urge all of my colleagues to join me in supporting it.

Mr. NICKLES. Mr. President, how much time remains to both sides?

The PRESIDING OFFICER. The Senator from Oklahoma has 19 minutes and the Senator from Massachusetts has 9.

Mr. NICKLES. I yield my colleague from Tennessee 8 minutes.

Mr. FRIST. Mr. President, there has been a lot of misinformation and I am sure a lot of confusion on the part of many because of allegations that have gone back and forth because of the rhetoric, so I think I will use my few minutes to outline what is in the Patients' Bill of Rights Plus Act; that is, the Republican leadership bill we have been discussing for the last several days.

I am very proud of the bill we have put forward. I am proud of it as a physician, as a member of the task force that helped put this bill together, and as a Senator, because I believe with passage of this bill we can do what I think everybody in the body wants to do, and that is to improve the quality of care for individuals across this country, their children, and on into the next generation.

The bill we put forward has really six major components with three objectives. The three objectives are to enhance health care quality, to enhance access, and to provide consumer protections. We do that through six components.

First, as the Senator from Maine has just gone through, strong consumer protection standards. The second way of achieving that is that we offer good, comparative information among plans, at a time when it is very confusing to the beneficiary, to the individual patient, what plan offers what, and what benefits are covered.

Third—and I am proud of this—we have a strong internal, and even more important, I believe, external appeals process establishing these rights for 124 million people. We are talking about scope in a lot of these discussions, but let's remember this applies to 124 million Americans who are covered both by the self-insured and fully insured group health plans.

Fourth, we have in our bill a ban on the use of genetic information by insurance companies for underwriting purposes. It is very important, as we look at the human genome project, which is producing 2 billion bits of information, all of which can be to the benefit of mankind if it is used appropriately.

Fifth, we have a quality focus in our bill which is lacking in other bills and other proposals. We have expanded quality research activities through the Agency for Health Care Policy and Research. We address issues of access. This is in contrast to the bill on the other side, because we have a major problem in this country today of about 41 million people who are uninsured. You are not going to find this Senator voting for a bill that drives people to the ranks of the uninsured and expands that 41 million to 42 million.

As my colleague from Maine just pointed out, every 1-percent increase in premiums drives about 300,000 people to the ranks of the uninsured. I doubt one will find very many Senators on our side in favor of increasing that number of uninsured.

We addressed the issue of access through two means: No. 1 is medical savings accounts expansion, and No. 2 is to have availability of a full deduction for health insurance benefits for the self-employed.

As the Senator from Maine pointed out, States already regulate insured health plans. Thus, our bill addresses the unprotected with the protections. We do it through emergency care. A prudent layperson, somebody in a restaurant has some chest pain—is it indigestion or a heart attack? You go to the emergency room and are reimbursed, because a prudent layperson standard is used and, therefore, that service is covered.

Choice of plans: In our bill, we make sure those plans that offer network-only plans are required to offer what is called point-of-service options.

Consumer protections: Obstetricians, gynecologists, pediatricians—we have heard these words used a lot. Who are these physicians? Do you have access? Under our bill, health plans would be required to allow direct access to obstetricians, to gynecologists, and to pediatricians for routine care without referrals, without gatekeepers.

Continuity of care: Under our bill, plans that terminate or nonrenew doctors or providers from their networks would allow continued use of the provider for up to 90 days or, if someone is pregnant, up through the postpartum period.

Access to medication: We all know that formularies are used increasingly by people broadly because of the cost of prescription drugs. In our plan, we make sure physicians and providers and people with clinical experience are on those boards that put together these formularies. In our bill, we make sure that nonformulary alternatives are available when medically necessary and when appropriate. Physicians, pharmacists, not just bureaucrats, will be putting these formularies together.

Access to specialists: I am a heart and lung transplant surgeon. I have had the opportunity to transplant hundreds of hearts and lungs and do hundreds of heart operations, and I know the importance of access to a specialist. Under our bill, health plans would be required to ensure that patients have access to covered speciality care within the network or, if necessary, provide that access through contractual relationships if heart surgeon BILL FRIST happens not to be inside that network.

Gag rules: We all know that physicians should not have gags placed on them when they talk to patients. We have a strong gag rule prohibition in our bill. No more gag rules.

A second approach is that we require comparative information be given to individuals so they can compare one plan to another so they will know what services are covered and what services are not.

I mentioned grievance and appeals. All group health plans would be required to have written grievance procedures and have both an internal appeals process as well as an external appeals process if there is some disagreement as to what is covered and what is not covered.

Timeframes—we address it in our bill. Expedited requests for care, if there is any question of jeopardizing the patient's health, is allowed.

Qualification of reviewers: This is a significant improvement in our bill compared to last year. We make absolutely sure that an appropriately qualified external reviewer; that is, a provider who has expertise in the field where there is some question. If it is a question about heart surgery, you have a heart surgeon, somebody familiar to heart surgery as the reviewer. The external appeals process is, I believe, greatly strengthened by having this independent—and those are the words we use—''external medical reviewer where necessary.''

We allow in those cases where a treatment is considered experimental that that also can be handled in this external review process. We require that external reviewer to have ''relevant expertise.''

My time is just about out. There are three other issues.

Genetic information: Our bill recognizes that ''predictive genetic information'' can be used against you by an insurance company, either raising premiums or denying coverage. We prohibit it.

Our bill focuses on quality improvement by taking the Agency for Health Care Research and Quality and focusing on health service delivery and training scientists, providing information systems to improve quality, and, lastly, our bill invests in the infrastructure necessary to measure quality.

Medical savings accounts and full health insurance deduction for the self-employed are a part of our bill.

That is our bill in a nutshell. It looks at consumer standards. It looks at improved quality, it looks at improved access. It is a bill of which I am proud. It is a bill I know all of us can support. It is a bill that will improve health care in the United States of America.

Mr. President, I yield back my time.

Mr. SCHUMER addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. I have been yielded 4 minutes by the Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. SCHUMER. I thank the Chair, and I thank the Senator from Massachusetts not only for yielding but for his leadership over many years on this issue. Let me make a couple of points.

First of all, the Senator from Tennessee has outlined his bill, and it is a different approach. I ask Americans to ask: Why do all of the leading doctors' groups, including the American Medical Association, why do the leading consumer groups up and down the line, support our approach? If the bill on the other side is so good for consumers and so good for physicians and providers, then why are they all supporting this bill? And if, as the Senator from Tennessee believes, all of these are worthy goals—specialists, appeals processes, et cetera—then why not go all the way? Why not do it right? Why not do it in a way that the AMA and all the consumer groups and all of those that both sides are talking about protecting choose? The bill they choose is our bill.

Second, on cost, because I know the Senator from Maine mentioned cost, the most recent estimates by CBO said that the Daschle-Kennedy bill, at the end of 5 years, would cost $2 extra a month a person. Ask Americans: Would they pay that to have access to specialists, to have emergency room treatment, to have the kinds of things we have been talking about? You bet. They would pay it in a New York minute. So if cost is the concern, it is not much, and you get a lot. If helping providers and consumers is the concern, our bill prevails.

What we are going to do tonight is table any proposal. That is not adequate, nor is it even adequate, at least from my point of view as a freshman Senator, to try to deal with this issue and just push it away. We believe passionately that patients need help, that consumers need help, that physicians and nurses and hospitals need help.

We believe the HMOs have swung too far in their ability to police the basic patient-doctor relationship. We do not think that a quick ''let's get rid of this, let's have a quick vote and say it is over'' serves the American people.

What we will be doing on this side is continuing to fight until we can get a full and open debate. I want to debate the Senator from Tennessee on whether the Daschle bill or his bill really gives access to specialists. I want to debate the Senator from Tennessee on whether the appeals process in our bill or in his bill is the most open.

I want to debate the Senator from Tennessee on every one of the issues that has been mentioned. The process that we are going through now does not allow that debate. I do not know where it will come out. My guess is it may come out similar to the last debate we had where a number of people, in a bipartisan way, come together for a stronger bill. But that may not happen.

But at the very least, in conclusion, we should have a full and open debate. And a motion to table and a vote on one bill and then the other to get rid of this is not fair to the American people.

Thank you.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. NICKLES. Mr. President, how much time remains?

The PRESIDING OFFICER. Eleven minutes for the Senator from Oklahoma.

Mr. NICKLES. On the other side?

The PRESIDING OFFICER. Four minutes 46 seconds.

Mr. NICKLES. I yield the Senator from Pennsylvania 5 minutes.

Ms. SANTORUM. Thank you, Mr. President.

I thank the Senator from Oklahoma for yielding me time. I congratulate him and the entire working group on the Republican side of the aisle—Senators JEFFORDS, COLLINS, FRIST, and GRAMM for putting together what I believe is a bill that this Senate should embrace. I think America, if they were given the choice between what is being offered on the Democratic side and what is being offered on the Republican side, would quickly embrace this plan for many reasons.

No. 1, it is a much more comprehensive plan. This is the Patients' Bill of Rights Plus. It is not just some consumer protection measures which Democrats have put forward—and we have, to some degree, done the same—but it goes much farther. By looking at the health care picture in America, on a comprehensive basis, we took a step back and said, what can we do to improve quality, to improve access, to reduce costs—not responding to hot button poll issues?

It seems to be the popular move around here—when something polls well, we rush out here and try, with legislative fixes, to pass something that sounds good to the American public.

We did not take that approach. We took the approach of how, from a public policy point of view, we are going to solve real problems in America—not real problems that maybe poll well but real problems that solve structural problems, structural problems in the health care system, which will end up benefiting millions of people.

One such area is that of access. Much has been talked about in relation to patients' rights. We have not heard a lot of talk on the other side about access to insurance. There are a couple of components to that.

No. 1, keep the costs down. We have heard a lot of talk about how the other bill, the Kennedy bill, dramatically increases costs. Our bill does not do that.

So in that respect, we already, by virtue of not driving up health care costs, improve access. But we do more than that.

We do two specific things in the tax portion of this bill. First, we increase the deductibility of insurance for the self-employed up to 100 percent. So we put them on an even playing field with those who have employer-provided health care. We give 100 percent deductibility, thereby increasing the desirability of owning health care insurance, of buying that insurance for yourself as a self-employed individual, thereby getting more people into the health care system, which is something everybody believes is necessary and desirable.

Second, we provide for medical savings accounts. Medical savings accounts have gotten, from a public policy perspective, a little bit of a bad rap based on what was passed here a few years ago. What was passed here a few years ago was a program that was designed to fail. Those who designed it got exactly what was predicted—failure.

It is a program that is very limited. Very few taxpayers can participate in it. It is time limited. It does not allow you to carry contributions from year to year. It is a program that has very little in the way of a design that would be attractive. In fact, what would attract people to MSAs is the ability to control their own health care costs, which is the ability to profit personally—instead of the insurance companies managing your health care, doing things that keep you healthy. Those are some of the attractions of MSAs that are the control element, all of which are forfeited under the existing MSA proposal.

The bill that we are offering removes all these restrictions—artificial—to dampen the enthusiasm for the program, to make it less attractive and less workable, and allows a full-blown medical savings account proposal to go forward and to put it into the mix of health care delivery options, insurance options, again, creating more choices, creating, in this case, a high deductible insurance option that is very attractive to people who we have a very difficult time bringing into the insurance system but are very important to get in there, and those are younger workers, in particular.

We have a very difficult time convincing younger uninsured people that it is maybe worthwhile to go out and buy insurance coverage. Most young people think they are infallible, that they cannot be hurt, that they do not need insurance. What we do is create a savings component to health insurance which is a very attractive thing, particularly for younger people and yet, at the same time, very useful for everyone—once people understand how the dynamics of medical savings accounts work.

So it has the dual components of attracting those very desirable people into the insurance pool—younger workers who have, in fact, less health care costs—and at the same time provides the kinds of choices and quality and the proper incentives to the rest of the population in the health care system through these medical savings accounts.

So I am very excited that what we have been able to accomplish in this bill is not just to provide some hot button issues with regard to HMOs which poll well—and I understand that——

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SANTORUM. We have provided a comprehensive approach to health care reform and one that I think we can all be very proud of.

I thank the Senator from Oklahoma for yielding me time.

Mr. KENNEDY. I yield 2 minutes to the Senator from Illinois.

Mr. DURBIN. I thank the Senate for yielding.

You know what this reminds me of? This reminds me of the Senate. Imagine, both sides of the aisle—Republican and Democrat—on the floor discussing and debating an issue which counts with American families—health insurance.

Is it going to be there when we need it? Will it be affordable? Can we trust our doctors not to be overruled by insurance company bureaucrats?

I like this debate. That is why I ran for the Senate. But in 10 minutes there will be a vote on a Republican motion to table to end this debate, to stop it, to say that there is going to be no further debate, no future amendments—it is over.

I do not think that makes sense. Weren't we sent here to enter into this debate? To face these issues on an up-or-down vote? I am prepared to do that.

I know that some of the votes on these amendments will not be easy, but I think we have an excellent bill in the Democratic Patients' Bill of Rights, a bill that has been endorsed by every major health organization, children's advocacy groups, and labor-business across the board.

I am prepared to stand and defend this bill, offer amendments that give to families the assurance they are going to get quality health care. But the Republican side does not want this debate. They do not want to vote on these amendments. They called it ''health care-plus.'' It is ''health care-minus.'' Every day they are taking away from American families their power to choose a doctor, their power to have the right specialist, their willingness, I guess, to sit down with their doctor and realize they are getting an honest answer.

It is a shame that in 10 minutes this motion to table is going to come before us. This really resembles the Senate—deliberation on an issue that counts. I hope the motion to table is defeated. Let's have the real debate on this issue.

I yield back my time.

Mr. BINGAMAN. Mr. President, I rise to today to ask my colleagues to consider several intriguing questions. What would we do if I told you that Americans were deliberately being denied access to our country's greatest technologies and developments? What if I told you that there is a business in this country that is permitted to make any kind of business decision they want and potentially adversely effect millions of consumers' lives and not be held accountable? What if I told you that Congress has had the answer to these questions and, most importantly, the solutions to these problems but because of a few people and a great deal of money from one special interest group, the American people have been denied a substantially better quality of life? Well, unfortunately, all this is true.

Over 200 organizations representing doctors, nurses, patients' right advocates, consumer organizations and labor groups and American people everywhere have all spoken loud and long: The time is now to pass a meaningful patient's bill of rights. My Democratic colleagues stand ready, once again, to engage in a discussion with our Republican colleagues so that we can finally put the American people's interest before health insurance company profits.

Over 100 million workers who labor hard and pay health insurance are being denied critical medical services. We are led to believe by some that the health care system under managed care is working just fine. In our own circles of friends and family, we know that this is simply not true. The numbers are staggering. I have a chart here that will not surprise anyone.

In 1998, 115 million Americans either had a problem or knew someone who had a problem with managed care and that number is dramatically on the rise. Let me say that again. At least, 115 million people in this country are experiencing difficulties obtaining medical services for which they pay for every month. The issue is clear. Managed health care reform is long overdue.

First and foremost, we need a managed health care system that is inclusive, providing the best health care for everyone that spends their hard earned dollars on health insurance. The Republican managed care bill leaves out over 100 million Americans: two-thirds of those that have private health insurance. Let me be even more specific using my own State, New Mexico, as a example of what I am referring to.

There are approximately 900,000 privately insured patients in the State of New Mexico. Without passage of the

Democratic Patients' Bill of Rights, look at the list of major patient protections that over 900,000 New Mexicans will not have.

Under the Republican bill, almost 700,000 New Mexicans will not have substantive protections and 350,000 will not be covered at all if the Republicans pass their bill. The Democratic Patients' Bill of Rights will assure that 900,000 New Mexicans will receive all these protections that I have listed on this chart.

These numbers represent real people with real health concerns. These numbers represent people who expect Congress to put the health interests of Americans first.

Let me address just a few of the basic protections that I believe a managed care system should provide and that, in fact, the Democratic Patient's Bill of Rights includes.

We need a managed care health system that does not financially penalize health care professionals who try to provide the best care for their patients. We can no longer permit managed care companies to fire providers who report quality concerns or who speak up on behalf of their patients and assist their patients when their HMO denies care.

We need a managed care health system that does not allow HMO's to operate with few providers and long waiting periods for appointments, and that force patients to drive long hours to get needed care, even if there are qualified providers nearby. Where you live in our country should not be reason enough to exclude you from the best medical care available. In a state such as New Mexico this is a critical concern.

We need a managed care health system that does not prohibit health plans from excluding non-physician providers such as nurse practitioners, psychologists, and social workers from their networks. Under the Republican bill, patients, especially those in rural and other areas without an adequate supply of physicians, could be left out in the cold. Once again, in the State of New Mexico these are critical concerns.

Simply put, we need a managed health care system that puts patient protections first before insurance company profits.

Let me also address one other issue. I have heard concerns from some of my Republican colleagues regarding the impact that reforming health insurance might have on small businesses. I too have long been concerned with the effect of federal policy on this part of the business sector. New Mexico relies significantly on the innovation and hard work of the small businessperson and I have consistently worked to protect their interests. But instead of trying to scare small businesses with inadequate information that seemingly threatens their livelihoods as some might do, let's take a look at the facts.

In a recent study by the Small Business Alliance and the Kaiser Family Foundation, the overwhelming majority of small businesses would continue to provide health insurance after managed care reform and the majority of these business endorsed key elements of the Democratic Patient's Bill of Rights including real independent appeals, access to speciality care, and direct access to OB/GYN services, as well as the patient's right to hold insurance companies accountable for their decisions.

I began my comments asking several fundamental questions about consumer rights. I would like to conclude by encouraging all of my colleagues to consider the issues which I have raised and I look forward to substantive debate on these critical matters that have such a profound effect on the health of this Nation.

We have an opportunity to stand up for American families, protect American children and respond to the needs of American workers. I urge all of my colleagues to stand together with the overwhelming majority of the American people and begin a discussion that will ultimately lead to the passage of a meaningful patient's bill of rights for all Americans. The American people have waited long enough.

Mr. CHAFEE. Mr. President. I would like to clarify my position on these procedural votes regarding managed care reform legislation.

I think Senators on both sides of the aisle are familiar with my position on the need for managed care reform legislation to ensure that health care consumers are treated fairly by their HMOs and other managed care plans.

Indeed, I have authored bipartisan legislation—both in this Congress and the last—to provide a basic floor of federal protections for all privately insured Americans. And, I am pleased to be joined in that endeavor by Senators BOB GRAHAM, JOE LIEBERMAN, ARLEN SPECTER, MAX BAUCUS, CHUCK ROBB and EVAN BAYH.

Though I will vote not to table the Republican bill, I want to make clear, I do not think this bill goes far enough in protecting consumers. Nor am I entirely comfortable with the Democratic bill. Let me cite just a few examples.

In the Chafee-Graham-Lieberman bill, our patient protections would extend to all privately insured Americans—not just to the self-funded component of the ERISA population, as is the case with most of the patient protections in the Republican bill.

A credible enforcement mechanism is also critical to ensuring that any patient protections we adopt here in the Senate are taken seriously by managed care plans. The Chafee-Graham-Lieberman bill contains a strong enforcement mechanism which would permit injured parties to seek redress in federal court. Here the Democratic bill goes too far in exposing health plans to state tort liability, while the strengthened ERISA remedy contained in the Republican bill does not go far enough.

Our bipartisan bill also contains very strong internal and external appeals provisions to ensure that patients get their appeals heard in an expeditious and equitable manner. I am not convinced the Republican bill does enough in this area.

Regardless of our legitimate differences, I am not in favor of trying to force the debate on managed care in this manner. I respectfully urge both sides to work in good faith to arrive at a reasonable time agreement to facilitate an orderly debate as soon as practicable on this very important legislation.

In that regard, I do not think 40 amendments on either side is realistic given all of the other matters competing for the Senate's attention; nor, for that matter, do I think 3 amendments would give the Senate the opportunity to fully debate these issues.

If we are serious about Senate consideration of managed care legislation—as I believe both sides are—I see no reason why we cannot come to an agreement on a date certain for taking up this legislation, and a date certain for completing it. I believe the Senate could complete consideration of this legislation within a period of five or six days.

So, let us proceed in a timely manner to debate these differences and to vote to resolve them. That is our task, and I am willing to help in whatever ways I can to ensure a full and meaningful debate.

Mrs. MURRAY. Mr. President, I rise today to express my frustration and outrage with the inability of the Republican leadership to allow a fair and open debate on a real Patients' Bill of Rights. I do not like the idea of tying up must do appropriations bills to try and force a fair and open debate on access to health care services. However, due to the inability to find a reasonable compromise on the number of amendments, we have been forced to bring this issue to every possible vehicle.

There are many things we do here that simply do not have the impact we seem to think they do. We spend more time debating a constitutional amendment to balance the budget instead of simply doing the hard work to balance the budget. We proved that despite weeks of debate all we needed to do was make the tough choices and balance the budget. Yet when it comes to something like access to emergency room treatment or access to experimental life saving treatments, we can't find three days on the Senate floor. This is the kind of legislation that really does impact American working families. I

would argue that it deserves a full and open debate on the Senate floor.

The pending amendment before us is not, and let me repeat, is not a Patient Bill of Rights. Oddly enough it excludes most insured Americans and in many cases, simply reiterates current insurance policy. It does not provide the kind of protections and guarantees that will ensure that when you need your insurance it is there for you and your families. Let's face it, most people do not even think about their health insurance until they become sick. Certainly insurance companies do not notify them every week or month when collecting their premiums that there are many services and benefits that they do not have access to. It is amazing how accurate insurance companies can be in collecting premiums, but when it comes time to access benefits it becomes a huge bureaucracy with little or no accountability.

The Republican leadership bill is inadequate in many areas. Let me point out one major hole in this legislation. During markup of this amendment in the HELP Committee I offered a very short and simple amendment to prohibit so-called ''drive through mastectomies.'' My amendment would have prohibited insurance companies from requiring doctors to perform major breast cancer surgery in an out patient setting and discharging the woman within hours. We saw this happen when insurance companies decided that there was no medical necessity for a woman to stay more than 12 hours in a hospital following the birth of a child. They said there was no need for follow up for the newborn infant beyond 12 hours. There was no understanding of the effects of child birth on a woman and no role for the woman or physician to determine what is medically necessary for both the new mother and new born infant.

I offered the drive through mastectomy prohibition amendment only because an amendment offered earlier in the markup would continue the practice of allowing insurance personnel to determine what was medically necessary. Not doctors or patients, but insurance company bean counters. I offered my amendment to ensure that no insurance company would be allowed to engage in drive through mastectomies. My amendment did not require a mandatory hospital stay. It did not set the number of days or hours. It simply said that only the doctor and patient would be able to determine if a hospital stay was medically necessary. The woman who suffered the shock of the diagnosis of breast cancer; the woman who was told a mastectomy was the only choice; the woman who faced this life altering surgery. She decides.

Unfortunately, my colleagues on the other side did not feel comfortable giving the decision to the woman and her doctor. They did not like legislating by body part. Neither do I. But I could not sit by and be silent on this issue. Defeating the medically necessary amendment offered prior to my amendment, forced me to legislate by body part. I would do it again to ensure that women facing a mastectomy are not sent home to deal with the physical and emotional after shocks.

For many years I have listened to many of my colleagues talk about breast cancer and breast cancer research or a breast cancer stamp. When it sometimes to really helping breast cancer survivors, some of my Republican colleagues vote ''no.'' I hope we are able to correct this and give all of my colleagues, not just those on the HELP Committee the chance to vote ''yes.''

I also want to remind many of my colleagues who support doubling research at NIH, that we are facing a situation where we have all this great research and yet we allow insurance companies to deny access. Today we heard testimony at the Labor, HHS Subcommittee hearing about juvenile diabetes. It was an inspiring hearing with over 100 children and several celebrities. Yet as I sat there listening to testimony from NIH about the need to increase funding and how close we are to finding a cure, I was struck by the fact that the Republican leadership bill would allow the continued practice of denying access to clinical trials, access to new experimental drugs and treatments, access to specialities and access to speciality care provided at NIH cancer centers.

It does little good to increase research or to find a cure for diabetes or Parkinsons disease if very few can afford the cure or are denied access to the cure. We need to continue our focus on research, but cannot simply ignore the issue of access.

I urge my colleagues to join with me in supporting a real Patient's Bill of Rights that puts the decision on health care back into the hands of the consumer and the physician. It does not dismantle managed care. But it ensures that insurance companies managed care, not profits.

I do not want to increase the cost of health care costs, I simply want to make sure that people get what they pay for. That they have the same access to cure that we as Members of the Senate enjoy as we participate in the Federal Employees Health Benefit Plan. The President has made sure that we have patient protections. Our constituents deserve no less.

Mr. SPECTER. Mr. President, I am voting against tabling both competing versions of the Patient's Bill of Rights because I believe both should be considered by the Senate. I oppose any proposal to limit amendments on either bill and then have just an up or down vote on each Bill.

I believe a bill should be considered in regular order in the usual manner subject to the Senate rules which would permit amendments and debate under our rules without a unanimous consent agreement limiting amendments or debate.

My own preference for the Patient's Bill of Rights is the bipartisan proposal S. 374 sponsored by Senators CHAFEE, GRAHAM, LIEBERMAN, BAUCUS, and myself.

If any bill is called up subject to regular order, the various provisions could be considered and voted upon and the Senate would work its will on the competing provisions.

Mr. KENNEDY. How much time do I have?

The PRESIDING OFFICER. Two minutes 50 seconds.

Mr. KENNEDY. Two minutes 50 seconds?

The PRESIDING OFFICER. Yes.

Mr. KENNEDY. I would like to reserve the last 20 seconds, Mr. President.

Mr. President, to listen to my friends on the other side, you would think that you were hearing the talking points written by the insurance industry: It costs too much.

Here is the CBO report: 4.8 percent for average premiums for employer-sponsored health insurance over 5 years. For the sake of this exercise, call it 5 percent. Say a families' premium is $5,000. That is $250 over 5 years. Allocate that in terms of employer-employee, and you will find that the cost paid by an employee is around the cost of a Big Mac each month. This is a buy to ensure that you are going to have the protections in our legislation.

We hear about all the things that their program is doing. But the one thing that Senator FRIST left out is that they are only covering a third of all of Americans. They are leaving out more than 110 million Americans. If this plan is so good, why not include everyone?

For those that are so concerned about the cost, I hope they are going to explain where they are getting the money that the Joint Tax Committee says their proposal will cost. Their medical savings accounts alone—which are little more than a tax shelter for the rich—are $4.2 billion over the next 7 years. But they don't say how they will pay for it in their proposal.

They are concerned about cost? Why are they expanding that tax loophole? Why aren't they at least jawboning the insurance companies to hold down the 6 to 10 percent increase that we see in the insurance premiums every year just to increase profits?

Every single provision of the Republican bill is riddled with loopholes. It is a bill that only an insurance company accountant could like. As this debate proceeds, we will expose those loopholes.

Mr. President, one of the ways you know a person is by who their friends

are. Our friends in this debate are the 200 groups that represent the doctors and nurses—the health delivery professionals—and consumers. Not a single organization supports the opposition.

If our amendment is tabled, it is a vote against children, a vote against families, a vote against women; it is a vote against every individual with a serious health problem, and it is a vote in favor of mismanaged care and a vote in favor of placing insurance company profits ahead of patient care. I hope the motion to table Senator DASCHLE's amendment is defeated.

I yield the remainder of my time.

Mr. NICKLES. Mr. President, how much time remains?

The PRESIDING OFFICER. The majority has 5 minutes 4 seconds, and Senator KENNEDY has 20 seconds.

Mr. NICKLES. Mr. President, I yield 3 minutes to the Senator from Maine.

Ms. COLLINS. Mr. President, I thank the assistant majority leader.

The goal of any patients' rights legislation should be to resolve disputes about coverage, about access to treatment upfront when the care is needed, not months or even years later in a courtroom. That is a fundamental difference between the bill supported by Senator KENNEDY and the proposal that we have advanced.

Our legislation would accomplish this goal by creating a strong internal and external review process. If a patient or a physician is unhappy with an HMO's decision, the patient or the provider can appeal it internally for a review. If they are unhappy with the review decision, the internal review, they have the right for a free and quick review by an external panel. The goal of our legislation is to ensure that people get the treatment they have been promised.

Moreover, the decision of the outside reviewers is binding on the health plan but not on the patient. If the patient is still not satisfied, he or she retains the right to sue in Federal or State court for attorneys' fees, court costs, value of the benefit, and injunctive relief.

Our bill places treatment decisions in the hands of physicians, not trial lawyers. If your HMO denies you the treatment your doctor believes is medically necessary, you should not have to resort to a costly and lengthy court battle to get the care you need. You should not have to hire a lawyer and file an expensive lawsuit to get treatment.

Our approach contrasts with the approach taken in the measure offered by Senator KENNEDY. Their approach, which I do not support, would encourage patients to sue health care plans. You just can't sue your way to quality health care. We want to solve the problems upfront, when the care is needed, not months or even years later, after the harm has occurred.

According to the GAO, it takes an average of 33 months to resolve medical malpractice cases. This does nothing to ensure a patient's right to timely and appropriate care. Moreover, patients only receive 43 cents out of every dollar awarded in malpractice cases. The rest winds up in the pockets of trial lawyers and the administrators of court and insurance systems.

Suing is not the answer. The answer is having a fair, free, and prompt appeals process that gets patients the care they need, the care they were promised before harm can be done.

I recently met with a group of Maine employers who expressed their very serious concerns about the Kennedy proposal to expand liability for health plans and employers. One of these employers was Bowdoin College in Brunswick, ME. I want to talk briefly about Bowdoin's experience.

They moved to a self-funded plan in order to improve the coverage provided to their employees. They now provide an annual physical, low-cost prescription coverage, and well-baby care. But they told me that if the Democrats' proposal to expand liability goes through, it would seriously jeopardize their ability to offer affordable coverage for their employees. They would return to the insurance market and to a plan less favorable to their employees.

I thank the assistant majority leader for yielding the additional minute. I yield back my time to the assistant majority leader.

Mr. NICKLES. Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator has 1 minute 12 seconds.

Mr. NICKLES. I will reserve 12 seconds.

In a moment there will be a motion to table the Republican substitute. I hope our colleagues will vote against that motion to table and then, hopefully, after that is not tabled, I will move to table the Kennedy amendment.

Mr. President, I will do so for a couple of reasons. One, it doesn't belong on the agriculture bill. I told my colleagues we are willing to come up with a reasonable time agreement and a limited number of amendments to debate this issue. It doesn't belong on the agriculture appropriations bill.

There are other reasons to table the underlying Kennedy amendment. If you want to increase health care costs, that is what this bill does. It will increase health care costs 5 percent, in addition to the 6, 7, 8, 9 percent of health care inflation. You are going to have a 13 or 14-percent increase in health care costs, which is going to increase the number of uninsured probably by 1.5 million, maybe more. We should not be passing legislation to put 1.5 million people into the uninsured category. That would be a serious mistake.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, the issue that is before us with the proposal that Senator DASCHLE has advanced is a very basic and fundamental one: Who ought to be making the decisions on your health care?

The whole concept behind the Daschle proposal is that we should let the medical professional guide that judgment—the doctor, nurse and patient together. That ought to be the basis of the judgment—not an accountant, not an insurance company official. That is really at the heart of this whole legislation. Our legislation protects that and preserves it.

The other legislation that is reported out of our committee fails to do it. That is why we have the support of the health care professionals and they do not. I hope we will have the opportunity to at least debate these various issues in an orderly way. That is what this battle is about. I hope that we will be able to continue with a reasonable procedure to permit the Senate to make a judgment.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I am afraid my colleague from Massachusetts didn't hear my colleague from Tennessee state that we do have internal appeals that are decided by physicians. We also have external appeals that are decided by experts in the medical community. So if his statement is correct, he should vote for our proposal. I encourage him to do so.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. LOTT. Mr. President, has all time expired?

The PRESIDING OFFICER. Yes.

Mr. LOTT. Mr. President, I move to table amendment No. 703 and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to table amendment No. 703. The yeas and nays have been ordered. The clerk will call the roll.

The legislative assistant called the roll.

The PRESIDING OFFICER (Mr. BROWNBACK). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 45, nays 55, as follows:

[Rollcall Vote No. 181 Leg.]

YEAS—45

Akaka	Boxer	Conrad
Baucus	Breaux	Daschle
Bayh	Bryan	Dodd
Biden	Byrd	Dorgan
Bingaman	Cleland	Durbin

Edwards	Kerry	Murray
Feingold	Kohl	Reed
Feinstein	Landrieu	Reid
Graham	Lautenberg	Robb
Harkin	Leahy	Rockefeller
Hollings	Levin	Sarbanes
Inouye	Lieberman	Schumer
Johnson	Lincoln	Torricelli
Kennedy	Mikulski	Wellstone
Kerrey	Moynihan	Wyden

NAYS—55

Abraham	Frist	Murkowski
Allard	Gorton	Nickles
Ashcroft	Gramm	Roberts
Bennett	Grams	Roth
Bond	Grassley	Santorum
Brownback	Gregg	Sessions
Bunning	Hagel	Shelby
Burns	Hatch	Smith (NH)
Campbell	Helms	Smith (OR)
Chafee	Hutchinson	Snowe
Cochran	Hutchison	Specter
Collins	Inhofe	Stevens
Coverdell	Jeffords	Thomas
Craig	Kyl	Thompson
Crapo	Lott	Thurmond
DeWine	Lugar	Voinovich
Domenici	Mack	Warner
Enzi	McCain	
Fitzgerald	McConnell	

The motion was rejected.

The PRESIDING OFFICER. The majority leader.

Mr. LOTT. Mr. President, I notify Senators that this will be the last vote tonight. Tomorrow at 9:30, we will resume consideration of the agriculture appropriations bill which will be clean of the Patients' Bill of Rights. I urge Members to offer amendments to the agriculture appropriations bill as soon as possible. I yield the floor.

AMENDMENT NO. 702

Mr. LOTT. Mr. President, I move to table amendment No. 702, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to table amendment No. 702. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 53, nays 47, as follows:

[Rollcall Vote No. 182 Leg.]

YEAS—53

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Chafee	Hutchinson	Smith (OR)
Cochran	Hutchison	Snowe
Collins	Inhofe	Stevens
Coverdell	Jeffords	Thomas
Craig	Kyl	Thompson
Crapo	Lott	Thurmond
DeWine	Lugar	Voinovich
Domenici	Mack	Warner
Enzi	McCain	

NAYS—47

Akaka	Biden	Breaux
Baucus	Bingaman	Bryan
Bayh	Boxer	Byrd
Cleland	Inouye	Moynihan
Conrad	Johnson	Murray
Daschle	Kennedy	Reed
Dodd	Kerrey	Reid
Dorgan	Kerry	Robb
Durbin	Kohl	Rockefeller
Edwards	Landrieu	Sarbanes
Feingold	Lautenberg	Schumer
Feinstein	Leahy	Specter
Fitzgerald	Levin	Torricelli
Graham	Lieberman	Wellstone
Harkin	Lincoln	Wyden
Hollings	Mikulski	

The motion was agreed to.

Mr. LOTT. Mr. President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. LOTT. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. LOTT. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

STEEL IMPORT LIMITATION ACT

Mr. MCCAIN. Mr. President, unfortunately I was unable to vote on the cloture petition on the motion to proceed to H.R. 975, the Steel Import Limitation Act. If I was able, I would have voted against cloture. This legislation will not achieve its desired purpose and will only hurt American workers and consumers.

Some supporters of this legislation have asserted that this bill is necessary to support the steel industry. I am willing to do my part to ensure that America continues to have the most efficient and competitive steel industry in the world. The domestic steel industry plays an important role in protecting our national security by ensuring that we will have enough steel to build ships, tanks, planes, and missiles to protect the United States. Additionally, steel remains an important input in large sectors of our economy, including transportation equipment, fabricated metal products, industrial machinery and construction.

However, this legislation is not written to save domestic steel jobs, but instead will jeopardize American jobs. For every 1 job that produces steel, 40 jobs in the downstream industries use steel. If Congress passes this quota legislation, it will cause a shortage and drastic increase in the price of steel that will threaten the jobs of the 8 million employees in steel-using industries. For example, Caterpillar, Inc. uses a heavy special-section steel for bulldozer track-shoes. This steel is not produced in the United States, so Caterpillar imports it from overseas to its American plants. If we pass this quota legislation, Caterpillar will not be able to import the steel it requires, which will threaten the jobs of Caterpillar's 40,261 workers in the U.S.

I also do not think that this quota legislation will help the steel industry. According to the Wall Street Journal, American steelmakers buy up to 25% of the steel coming into the United States. The steel companies need to buy this steel to reach their highest capacity of steel production. Weirton imports close to 400,000 tons of slab a year. Bethlehem Steel imported at least 416,000 tons of steel last year. If we shut off the necessary imports of foreign steel to these companies, how can they keep American steel product workers employed?

While I know that the steel industry has been affected by the dumping of foreign steel in the U.S. market, I believe that the proper steps have been taken to deal with this crisis. Since January, 1999, 42 antidumping and countervailing duty steel investigations have been initiated or completed. As a result of just one of these antidumping cases, duties of between 67.14% and 17.86% will be imposed on select Japanese firms. These duties will ensure that U.S. companies will have a better chance to compete.

That the existing process for handling anti-dumping cases is working is proven by the recent statistics on steel imports. Total steel imports dropped 42% from August, 1998, to April, 1999. In fact, April, 1999, imports are actually 6% below steel imports in April, 1997. Imports of hot-rolled steel, which account for 25 percent of all steel imports, fell 72% since the peak levels of November, 1998. Hot-rolled steel imports from Japan, Russia, and Brazil fell almost 100% from November to April. It is no wonder that Secretary Daley said in the Friday, June 18, Washington Post that ''the steel crisis of '98, in my opinion, is over.'' Given the decline in recent imports, there seems to be no need for this legislation. These results, under existing law, were attained in a manner fully consistent with our obligations under the World Trade Organization.

This leads me to a more important point. We should not look at this legislation in only the narrow view of what it will do for the steel industry. Instead, we should see what it will do to the world economy.

The past two years have been devastating for many of our trading partners. Most of Asia is slowly turning the corner back from the disaster of the Asian economic crisis. Just recently, Japan announced a positive growth rate of 1.9% after six successive quarters of contraction. Both Brazil and Argentina have suffered from economic turmoil. In Europe, the Russian economy remains a basket case. Germany, the former European economic powerhouse, grew a mere 0.4% in real terms, and is on the verge of recession.

The United States must be careful not to do anything that will plunge the